Best Practices in Reproductive Health
in Kenya

The Division of Reproductive Health
Ministry of Public Health and Sanitation

August 2009
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<tbody>
<tr>
<td>ACCESS</td>
<td>Access to Clinical and Community Maternal, Neonatal, and Women’s Health</td>
</tr>
<tr>
<td>ADRA</td>
<td>Adventist Development and Relief Agency</td>
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<tr>
<td>AED</td>
<td>Academy for Education Development</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>AMKENI</td>
<td>Acronym which stood for a USAID funded project on RH/FP in Western and Coast (2001-2006)</td>
</tr>
<tr>
<td>AMREF</td>
<td>Africa Medical and Research Foundation</td>
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<tr>
<td>AMTSL</td>
<td>Active Management of the Third Stage of Labor</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
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<tr>
<td>AOP</td>
<td>Annual Operating Plan</td>
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<tr>
<td>APHIA</td>
<td>AIDS, Population, and Health Integrated Assistance Programme</td>
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<tr>
<td>ARK</td>
<td>Abstinence and Risk Avoidance</td>
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<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
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<tr>
<td>ASRH</td>
<td>Adolescent Sexual and Reproductive Health</td>
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<tr>
<td>BCC</td>
<td>Behavioral Change Communication</td>
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<td>BCS</td>
<td>Balanced Counseling Strategy</td>
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<tr>
<td>BP</td>
<td>Best Practice</td>
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<tr>
<td>BTL</td>
<td>Bilateral Tubal Ligation</td>
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<tr>
<td>CCP</td>
<td>Comprehensive Prevention Programme</td>
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<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<tr>
<td>CDF</td>
<td>Constituency Development Fund</td>
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<tr>
<td>CHN</td>
<td>Community Health Nurse</td>
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<tr>
<td>CHW</td>
<td>Community Health Worker</td>
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<tr>
<td>CM</td>
<td>Community Midwife</td>
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<td>CORP</td>
<td>Community Owned Resource Person</td>
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<tr>
<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
</tr>
<tr>
<td>CS</td>
<td>Caesarean Section</td>
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<tr>
<td>CSW</td>
<td>Commercial Sex Workers</td>
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<td>CT</td>
<td>Counseling Testing</td>
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<tr>
<td>DASCO</td>
<td>District AIDS and STI Control Office</td>
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<tr>
<td>DFID</td>
<td>Department of International Development</td>
</tr>
<tr>
<td>DHMB</td>
<td>District Health Management Board</td>
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<td>DHMT</td>
<td>District Health Management Team</td>
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<td>DMC</td>
<td>Division of Malaria Control</td>
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<td>DRH</td>
<td>Division of Reproductive Health</td>
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<tr>
<td>ESD</td>
<td>Extending Service Delivery</td>
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<tr>
<td>FANC</td>
<td>Focused Antenatal Care</td>
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<tr>
<td>FBO</td>
<td>Faith-based Organization</td>
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<tr>
<td>FCI</td>
<td>Family Care International</td>
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<tr>
<td>FGM</td>
<td>Female Genital Mutilation</td>
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<td>FHI</td>
<td>Family Health International</td>
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<td>FHOK</td>
<td>Family Health Options Kenya</td>
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<td>FOY</td>
<td>Friends Of Youth</td>
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<td>FP</td>
<td>Family Planning</td>
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</table>
GBV  Gender-based Violence
GBVR Gender-based Violence Recovery
GTZ Deutsche Gesellschaft fur Technische Zusammenarbeit (German Technical Corporation)
HAART Highly Active Antiretroviral Therapy
HBC Home-based Care
HIV Human Immunodeficiency Virus
HTA High Transmission Area
IBP Implementing Best Practices
ICPD International Conference on Population and Development
IEC Information Education and Communication
IMCI Integrated Management of Childhood Illness
IPT Intermittent Prevention and Treatment
ITN Insect Treated Net
IUCD Intrauterine Contraceptive Device
JHU Johns Hopkins University
JHPIEGO Johns Hopkins Program for International Education in Gynecology and Obstetrics
JICA Japan International Cooperation Agency
KARHP Kenya Adolescent Reproductive Health Programme
KDHS Kenya Demographic and Health Survey
KEPH Kenya Essential Package for Health
KENWA Kenya Network of Women with AIDS
KEPH Kenya Essential Package for Health
KFW German Bank for Reconstruction
KICOSHEP Kiberia Integrated Community Self-Help Programme
KMESA Kenya Medical Supplies Agency
KOGS Kenya Obstetrical and Gynecological Society
Ksh Kenya Shilling
LAPM Long-acting and Permanent Methods
LATF Local Authority Transfer Funds
MAP Men As Partners
MCH Maternal and Child Health
MDG Millennium Development Goals
M&E Monitoring and Evaluation
MGSCSS Ministry of Gender, Sports, Culture, and Social Services
MIP Malaria in Pregnancy
MIPESA Malaria in Pregnancy in Eastern and Southern Africa
MIS Management Information System
MLVCT Moonlight Voluntary Counseling and Testing
MNH Maternal Neonatal Health
MOH Ministry of Health
MPDB Medical Practitioners and Dentists Board
MSK Marie Stopes Kenya
MTP Medium Term Plan
MSI Marie Stopes International
NASCOP National AIDS and STI Control Programme
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>NAYA</td>
<td>National Youth Alliance</td>
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<tr>
<td>NHIF</td>
<td>National Hospital Insurance Fund</td>
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<tr>
<td>NCAPD</td>
<td>National Coordinating Agency for Population and Development</td>
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<tr>
<td>NCC</td>
<td>Nairobi City Council</td>
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<td>NNAK</td>
<td>National Nurses Association of Kenya</td>
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<tr>
<td>NGO</td>
<td>Nongovernmental Organization</td>
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<tr>
<td>NHSSP</td>
<td>National Health Sector Strategic Plan 2005-2010</td>
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<td>NYHP</td>
<td>Nyeri Youth Health Project</td>
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<tr>
<td>NYP</td>
<td>Nyeri Youth Project</td>
</tr>
<tr>
<td>OBA</td>
<td>Output-based Aid</td>
</tr>
<tr>
<td>OBS/GYN</td>
<td>Obstetrician/Gynecologist</td>
</tr>
<tr>
<td>PAC</td>
<td>Project Advisory Committee</td>
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<tr>
<td>PATH</td>
<td>Partners for Appropriate Technology in Health</td>
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<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
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<tr>
<td>PHC</td>
<td>Primary Health Care</td>
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<tr>
<td>PHMT</td>
<td>Provincial Health Management Team</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission</td>
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<tr>
<td>PPFA</td>
<td>Planned Parenthood Federation of America</td>
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<tr>
<td>PPC</td>
<td>Postpartum Care</td>
</tr>
<tr>
<td>PPH</td>
<td>Postpartum Hemorrhage</td>
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<tr>
<td>PP</td>
<td>Promising Practices</td>
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<td>PRCP</td>
<td>Post-rape Care Programme</td>
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<td>PSI</td>
<td>Population Service International</td>
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<td>PWC</td>
<td>Price Waterhouse Coopers</td>
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<td>RBM</td>
<td>Roll Back Malaria</td>
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<td>RH</td>
<td>Reproductive Health</td>
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<td>RHS</td>
<td>Reproductive Health Strategy</td>
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<tr>
<td>SAP</td>
<td>Structural Adjustment Programme</td>
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<tr>
<td>SM</td>
<td>Safe Motherhood</td>
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<tr>
<td>SCA</td>
<td>Skilled Care Attendant</td>
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<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<tr>
<td>SWAP</td>
<td>Sector Wide Approach</td>
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<tr>
<td>TA</td>
<td>Technical Assistant</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<tr>
<td>TFR</td>
<td>Total Fertility Rate</td>
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<tr>
<td>TOT</td>
<td>Training of Trainers</td>
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<tr>
<td>UON</td>
<td>University Of Nairobi</td>
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<tr>
<td>USA</td>
<td>United States</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>UNFPA</td>
<td>United Nation Population Fund</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
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<tr>
<td>VIA</td>
<td>Visual Inspection with Acetic Acid</td>
</tr>
<tr>
<td>VMA</td>
<td>Voucher Management Agency</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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</table>
Best Practices (BP) could be evidence-based, innovative practices, or practices based on lessons learned. The best practice would have been applied successfully in a given setting and could consist of evidence-based tools, materials, or actions. Replication and implementation of best practices would maximize the quality, efficiency, and effectiveness of reproductive health (RH) services for both women and men.

Globally, several efforts have been made to identify and document best practices in RH services to improve delivery. For instance, the Best Practices Initiative (BPI) launched by Advance Africa resulted in a compendium database of successful, evidence-based practices from around the world. The database compiled programme descriptions, training materials, and research reports that managers could use to improve the performance of their programmes. Additionally, the Implementing Best Practices in Reproductive Health (IBP Consortium was set up to advance documentation of best practices and to disseminate knowledge about them.

Kenya recognizes its need to identify existing best practices in RH and has made that a national priority. A deliberate effort should be made to refocus attention on the challenges and critical programmatic needs in the area of RH and to apply the best practices that have been identified. Currently, information on targeted and coherent programmes that have and have not worked is lacking, which has resulted in costly duplication of efforts and the implementation of ineffective programmes. Current, best-available evidence from relevant and valid research on the effects of different forms of health care is crucial for decisions about the management and care of individual patients and the delivery of health services, particularly in settings where resources are limited.

The Government of Kenya is committed to achieving the goals of the International Conference on Population and Development (ICPD) and the Millennium Development Goals (MDG) to ensure that adverse RH outcomes are reversed. The First Medium Term Plan (MTP) of Vision 2030 acknowledged the growing concern of reversals in RH gains made in the 1980s and early 1990s. The first global Reproductive Health Strategy (RHS) of the World Health Organization (WHO) is designed to accelerate progress towards attaining the international development goals and targets that were adopted by the 57th World Health Assembly in May 2004. WHO recognizes the crucial role of sexual and reproductive health (SRH) in social and economic development in all communities. In order to achieve these goals and fulfill part of its core mandate, the Head, Division of Reproductive Health (DRH) commissioned a task force to come up with a compendium of best practices in RH. This compendium of best practices is a contribution towards providing quality and standard, evidence-based RH practices at all service-delivery points throughout the country.

The process of developing the Compendium of Best Practices was not easy — first, a tool had to be developed to guide the selection of the best practices. I would like to thank all those who were involved in this lengthy and tedious process for a job well done. It is my sincere hope that the wide dissemination of these practices will contribute to improved standards for RH services.

Dr. Bartilol Kigen

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Ministry of Public Health & Sanitation
ACKNOWLEDGEMENTS

This Compendium of Best Practices was developed in collaboration with Kenya’s Best Practices Task Force, under the leadership of the Division of Reproductive Health (DRH).

The authors would like to thank Drs. Josephine Kibaru and Janet Wasiche, former heads of the DRH, for initiating, supporting, and encouraging the Best Practices development process. They would also like to thank members of the task force for their valuable support: Dr. Helton Jilo, former Deputy Head, DRH, and former chair of the task force; Dr. Bartilol Kigen, Chair and Deputy Head of DRH; Cosmos Mutunga, Programme Officer; Anne Njeru; Annie Gituto; Margaret Meme; David Nyaberi; John Mwangi; Rose Maina; Judith Maua; Mary Gathithu; Charity Ndwiga; Diana Karmar, DRH; Beatrice Okundi, HPI; Dorcas Kungu; Dr. Salome Ngatu, GTZ; Geoffrey Okumu, UNFPA; Joyce Lavussa, WHO; Stephen Wanyee, UNFPA; Nancy Kidula, WHO; Esther Muketo, FHOK; Eunice Masamo, DON; Susan Otieno, CNO’s Office; Roselyn Koech, DRH; Anne Mwangi; Charlotte Warren, Population Council; Paul Dielemans, EHS; Rosemary Kamunya; Catherine Ayuko, JHPIEGO; Prisca Odityo, DON; and Catherine Blair, Consultant for GTZ.

Thanks also to Dr. Solomon Orero, the consultant who worked tirelessly to provide the technical support that was required to develop this document.

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Special thanks to everyone who has supported the various projects that we are documenting, and to all of the Ministry of Health (MOH) field staff of health institutions who have worked diligently to ensure the success of the various interventions — sometimes under trying circumstances.

The Ministry extends its appreciation to the World Health Organization for technical and financial support and to Family Health International for administrative and additional technical support during the selection process and documentation of the best practices. Finally, the Ministry thanks the European Commission/African, Caribbean and Pacific Group of States/World Health Organization Partnership on Health Millennium Development Goals (EC/ACP/WHO Partnership on Health MDGs) for making this effort to document the best reproductive health practices possible.

Finally, the Ministry extends its appreciation to WHO for technical and financial support and to FHI for administrative and additional technical support during the selection process and documentation of the best practices.
Chapter 1. Introduction: Rationale for the Documentation

In 2008, the Department of Reproductive Health (DRH) commissioned a process to identify and document the best practices in reproductive health that have been implemented in the country.

Globally, several efforts have been made to identify and document best practices for improving service delivery in RH services. For instance, the Best Practices Initiative (BPI) launched by Advance Africa yielded a compendium database of successful, evidence-based practices from around the world. The database also contained programme descriptions, training materials, and research reports that managers could use to improve the performance of their programmes. The Implementing Best Practices (IBP) in Reproductive Health Consortium was set up to document best practices and to promote awareness of them.

The Kenyan National Health Sector Strategic Plan 2005-2010, which outlines and guides the health policy, has defined the integrated Kenya Essential Package for Health (KEPH) and determined how to deliver it. RH indicators form a significant proportion of the sector performance indicators and targets. The Government of Kenya has also committed itself to attaining various global and regional goals and targets, including the MDGs.

Over the past two decades, Kenya has witnessed a significant increase in the uptake of key maternal- and child-health services but there has been no statistically significant decrease in maternal and newborn mortality and morbidity. The high mortality is a result of pregnancy and pregnancy-related complications, from which an estimated 6,000 women die annually. In addition, the contraceptive prevalence rate has stagnated at 39 percent.

Kenya recognizes its need to identify existing best practices in RH, to refocus attention on the challenges and critical programmatic needs in this priority area, and to apply identified best practices to them. Currently, targeted and coherent information on programmes that have worked and those that have not is sparse. This has resulted in the costly duplication of efforts and implementation of ineffective programmes.

The use of current best-available evidence from research about the delivery of health services is also crucial in settings where resources are limited. In 2004, the WHO, United Nations Population Fund (UNFPA), and U.S. Agency for International Development (USAID) supported the IBP Consortium’s IBP-RH Initiative. Its goal is to build the capacity of health workers and policy-makers to use evidence-based RH practices. The IBP-Family Planning (FP) Initiative and the Safe Motherhood Demonstration Project (SMDP) are examples of documented good practices in Kenya. Many examples of best practices, however, are neither documented nor disseminated for countrywide use.
The DRH is interested in providing leadership and guidance to achieve quality services in Kenya. Implementation of best practices, which should go towards achieving this end, will encourage the transfer and exchange of knowledge among the stakeholders.

**Objectives**

The project’s goals are as follows:

- Develop, produce, and disseminate a document of the best practices in reproductive, maternal, and neonatal health in Kenya.
- Develop an implementation guide for managers of public health programmes.
- Orient service providers to understand the value of documenting and managing change.

**The process**

The first step was to establish a Best Practices Task Force, whose mandate was to lead the process and provide technical guidance to the DRH. Specifically, the task force was charged to do the following:

- Define a best practice (BP) and a promising practice (PP).
- Lead the process of identifying interventions that would be considered a BP or a PP.
- Develop a tool that would be used to evaluate the interventions under consideration.
- Help the DRH hire a consultant to implement the activity and create a report.
- Call for submissions of best practices to be considered for documentation.
- Make telephone calls to those who received the call for submissions.
- Collect submitted responses from the head of DRH and use the evaluation tool to analyze them.
- Coordinate with the DRH to request more information from respondents when necessary. (Getting further information proved to be a challenge, and the consultant emphasized to the task force that the DRH needed to request the missing information.)
- Write up the best practices following the directives of the evaluation tool.

The DHR coordinated the exercise with the assistance of the WHO and Family Health International (FHI), who provided technical and secretariat services.

The head of DRH sent out a call to all organizations running or implementing programmes in RH to submit entries to be considered for documentation as best practices. Fifty programmes were submitted, and of these, 37 were scored using the evaluation tool. The 37 programmes and the organizations that submitted them appear in the table below. (The acronyms are explained on pages 2ff.)
<table>
<thead>
<tr>
<th>No.</th>
<th>Organization</th>
<th>Programmes</th>
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<tbody>
<tr>
<td>1.</td>
<td>KFW/DRH/NCAPD</td>
<td>RH-OBA</td>
</tr>
<tr>
<td>2.</td>
<td>JICA/MOH</td>
<td>Improvement of health services with a focus on Safe Motherhood (SM) in Kisii and Kericho (SAMOKIKE)</td>
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<td>3.</td>
<td>Intrahealth</td>
<td>Capacity Project</td>
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<td>4.</td>
<td>GTZ-Health Sector Programme</td>
<td>RH and Health Care Financing</td>
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<td>5.</td>
<td>GTZ-Health Sector Programme</td>
<td>Alternative rites of passage and integrated dialogue — GBV and FGM</td>
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<td>6.</td>
<td>Population Council and Family Health Options</td>
<td>Friends of Youth (FOY)</td>
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<td>7.</td>
<td>Frontiers Program of the Population Council</td>
<td>Adolescent Reproductive Health (ARH) Program</td>
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<tr>
<td>9.</td>
<td>The Population Council</td>
<td>Strengthening Postpartum Family Planning through Focused Postpartum Care</td>
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<tr>
<td>11.</td>
<td>JHPIEGO</td>
<td>Focused Antenatal Care (FANC), Malaria in Pregnancy (MIP)</td>
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<td>12.</td>
<td>JHPIEGO</td>
<td>Postpartum Hemorrhage</td>
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<td>13.</td>
<td>JHPIEGO</td>
<td>VIA/Villi screening for cancer of the cervix</td>
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<td>14.</td>
<td>AMREF</td>
<td>PMTCT in Kibera, Machakos, and Makueni</td>
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<td>15.</td>
<td>Hope World Wide</td>
<td>Comprehensive Prevention Programme (CPP)</td>
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<td>16.</td>
<td>Population Services International</td>
<td>Reproductive Health Brand — Femiplan</td>
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<td>17.</td>
<td>Liverpool VCT</td>
<td>Post-Rape Care Programme</td>
</tr>
<tr>
<td>18.</td>
<td>APHIA II Nyanza (Engender Health, CHAK, PATH, AED, IDCCS)</td>
<td>Delivery of integrated and comprehensive HIV/AIDS and RH/FP/CS services</td>
</tr>
<tr>
<td>19.</td>
<td>PPFA</td>
<td>Network of Adolescent and Youth of Africa (NAYA)</td>
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<tr>
<td>No.</td>
<td>Organization/Programme</td>
<td>Description</td>
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<tr>
<td>20.</td>
<td>WHO</td>
<td>Implementing Best Practices in Kenya</td>
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<tr>
<td>21.</td>
<td>Constella Futures/Health Policy Initiative</td>
<td>Advocacy to reposition FP/RH through Parliamentarians</td>
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<tr>
<td>22.</td>
<td>ADRA</td>
<td>Girl Child Improvement Programme</td>
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<tr>
<td>23.</td>
<td>FHI/MOH/NASCOP/DRH</td>
<td>Integrating FP into VCT Centers</td>
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<tr>
<td>24.</td>
<td>Walter Reed and Samaritans Purse</td>
<td>PMTCT at Tenwek Mission Hospital, Kaboson and Ngito dispensaries</td>
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<td>25.</td>
<td>World Vision/JHU/CCP</td>
<td>Abstinence and Risk Avoidance</td>
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<tr>
<td>26.</td>
<td>KENWA</td>
<td>Enhancing Community Capacity for Prevention, Care, and Treatment</td>
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<td>27.</td>
<td>Tumu Tumu Hospital</td>
<td>Improving RH Services</td>
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<td>28.</td>
<td>Karatina MOH</td>
<td>PMTCT</td>
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<td>29.</td>
<td>Aga Khan University Teaching Hospital</td>
<td>Maternal and Child Health Programmes</td>
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<tr>
<td>30.</td>
<td>APHIA II/PATH/Western</td>
<td>Comprehensive and integrated outreach services</td>
</tr>
<tr>
<td>31.</td>
<td>UON/University of Minnesota/DASCO/</td>
<td>MLVCT to Hard to Reach Populations — CSW, DJs, Bars, Hotels, Kenya Long Distance Drivers’ Welfare Associations</td>
</tr>
<tr>
<td>32.</td>
<td>Nairobi City Council</td>
<td>Working with Central MOH to implement health policies as a way of increasing access to health services—especially maternal health services—for the urban population, with financing from the local authorities and MOH of Kenya, to ensure supplies and commodities reach health facilities through KEMSA</td>
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<tr>
<td>33.</td>
<td>AMKENI/Population Council/MOH Bungoma</td>
<td>Delivery by Skilled Care Attendants</td>
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<td>34.</td>
<td>Nursing Council of Kenya/DRH</td>
<td>Pre-Service Nurse Training and Practice in Reproductive Health</td>
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<td>35.</td>
<td>UON/Dept of Obstetrics and Gynecology</td>
<td>Comprehensive Programme to Prevent Mother to Child Transmission of HIV/AIDS</td>
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<tr>
<td>36.</td>
<td>DRH/FHI</td>
<td>The IUCD Promotion Initiative Kenya Working Group</td>
</tr>
<tr>
<td>37.</td>
<td>FHI</td>
<td>New initiatives in PMTCT</td>
</tr>
</tbody>
</table>

The 13 submissions that were not evaluated were incomplete. The task force intended to evaluate the programmes in the following table, as well, but the implementing agencies did not submit them for consideration.
Table 2. Unsubmitted programmes

<table>
<thead>
<tr>
<th>Organization</th>
<th>Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNFPA/Nyanza PGH and Machakos District Hospital</td>
<td>Management of fistulae</td>
</tr>
<tr>
<td>UNFPA</td>
<td>Working with agricultural extension workers, training schools to include RH/HIV training in the curriculum</td>
</tr>
<tr>
<td>DRH</td>
<td>Maternal death review</td>
</tr>
<tr>
<td>Family Health Options, Population Council</td>
<td>Integration of RH/HIV as a cost-cutting initiative</td>
</tr>
<tr>
<td>FCI</td>
<td>Initiatives in Homa Bay to encourage women to deliver in health facilities by SCA</td>
</tr>
<tr>
<td>JHPIEGO</td>
<td>Cascade Model of on-the-job training (OJT), to reach more staff than other training models</td>
</tr>
</tbody>
</table>

The following criteria were used to rate the submissions. See the Appendix for the entry submission form that was used.

Table 3. Criteria for rating submissions

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Replicability</td>
<td></td>
</tr>
<tr>
<td>• Has been replicated elsewhere</td>
<td>30</td>
</tr>
<tr>
<td>• Using existing MOH of Kenya structures</td>
<td></td>
</tr>
<tr>
<td>Sustainability:</td>
<td>20</td>
</tr>
<tr>
<td>• Use of MOH of Kenya structure</td>
<td></td>
</tr>
<tr>
<td>• Use of local resources</td>
<td></td>
</tr>
<tr>
<td>• Availability of skilled human resources</td>
<td></td>
</tr>
<tr>
<td>• Participation by stakeholders</td>
<td></td>
</tr>
<tr>
<td>Increased service utilization:</td>
<td>40</td>
</tr>
<tr>
<td>• Evidence-based upward trend</td>
<td></td>
</tr>
<tr>
<td>• Creation of demand</td>
<td></td>
</tr>
<tr>
<td>Cost-effectiveness:</td>
<td>10</td>
</tr>
<tr>
<td>• Cost of the intervention</td>
<td></td>
</tr>
<tr>
<td>• Effect and benefits</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>100</td>
</tr>
</tbody>
</table>

A practice scoring 70 percent and above qualifies as a BP. Practices scoring between 50 and 69 percent qualify as a PP.
The consultant performed the following tasks:

- Analysis of all the submissions
- Identification of submissions that qualify as best practices and promising practices, according to the criteria set by the taskforce
- Identification of gaps in the submissions and follow-up for more information, where appropriate
- Compilation of the “Best Practices Report,” based on the submissions and information receive
Chapter 2. The Results of the Analysis

The results of the analysis are presented in the table below.

Table 4. Analysis of the responses to the call for the documentation of best practices

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>The total number of programmes or interventions that were submitted for consideration for documentation as best practices</td>
<td>50</td>
</tr>
<tr>
<td>The number of responses that were subjected to the tool used for analysis</td>
<td>37</td>
</tr>
<tr>
<td>The number of responses that were not subjected to the tool, because the submission form was incomplete</td>
<td>13</td>
</tr>
<tr>
<td>The number of submissions that qualified as best practices and for which further information for documentation was requested</td>
<td>8</td>
</tr>
<tr>
<td>The number of programmes or interventions that provided enough additional information to allow a write-up using the tool</td>
<td>5</td>
</tr>
<tr>
<td>The number of submissions that scored poorly according to the tool</td>
<td>15</td>
</tr>
<tr>
<td>The number of programmes or interventions that qualified as promising practices as per the tool</td>
<td>10</td>
</tr>
<tr>
<td>The number of PPs for which additional information was requested</td>
<td>2</td>
</tr>
<tr>
<td>The number of PPs that provided additional information for consideration for a write up</td>
<td>1*</td>
</tr>
<tr>
<td>The programmes or interventions that the task force felt were good practices but did not respond to the call for submissions</td>
<td>6</td>
</tr>
</tbody>
</table>

*Additional information was insufficient to allow evaluation using the tool
Chapter 3. The Best Practices

1. Focused Antenatal Care and Malaria in Pregnancy

Background

In Kenya, research by Graham and Murray (1997) documented that 95 percent of pregnant women go to an antenatal care (ANC) clinic, but only 41 percent are attended by a skilled care attendant (SCA) at delivery. According to the Kenya Demographic and Health Survey (KDHS) 2003, estimates of maternal mortality dropped from 590 per 100,000 in 1998, to 414 per 100,000. The low proportion of deliveries that were attended by skilled providers and an increasing number of home deliveries have caused maternal mortality to remain high. The data show that children born to women who obtained both antenatal and delivery care from trained service providers have lower mortality rates than children whose mothers received no antenatal or delivery care.

International evidence also shows that the most important factor in reducing maternal mortality is the attendance of a skilled provider during birth. The direct causes of maternal mortality in Kenya are haemorrhage, sepsis, pre-eclampsia, eclampsia, ruptured uterus, and complications from unsafe abortions. The indirect causes include malaria, anaemia, TB, and HIV/AIDS.

Malaria continues to be an important public health problem in Kenya. On average, malaria accounts for 30 percent of all cases seen in outpatient departments. Pregnant women—in particular, women experiencing their first and second pregnancies—are especially vulnerable to malaria infection and its harmful effects, such as severe anaemia and low birth weight (LBW) babies. Malaria also increases the risk of intrauterine growth retardation, premature labor, spontaneous abortion, stillbirth, and neonatal deaths. Public health interventions to minimize these risks must include efforts to prevent the incidence of malaria, and to effectively treat the disease if the woman has already contracted it. The use of intermittent preventive treatment (IPT) with Sulfadoxine-Pyrimethamine (SP) in pregnancy, as recommended by the WHO and by Kenya’s National Guidelines for Diagnosis, Treatment, and Prevention of Malaria for Health Workers, can reduce these negative outcomes of malaria in pregnancy (MIP). The intervention is a one-dose treatment of three tablets given twice during pregnancy: the first dose during the second trimester and the second dose in the third trimester. Treatments should be given at the antenatal care (ANC) clinic, thus making compliance more likely. The MOH of Kenya’s DRH and the Division of Malaria Control (DMC), in collaboration with the Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO), and with financial support from the British government’s Department of International Development (DFID), disseminated the National Guidelines for Malaria, particularly, the chapter dealing with malaria prevention in pregnancy and focused ANC.

ANC is one of the eight pillars of Safe Motherhood (SM). Its goal is to promote the health and survival of mothers and babies.
**Rationale**

It has been shown over the years that routine ANC has fallen short of the goals set for it. Although a high number of women attend ANC clinics, many are not helped by skilled birth attendants during delivery. The quality of ANC has been variously evaluated and found to be inadequate. Maternal mortality might not be completely preventable, but its incidence can be decreased with timely intervention. Focused ANC (FANC) with an emphasis on averting MIP is one of the interventions that can effectively address the delays that lead to maternal mortality.

The new focused ANC model does away with screening for risk factors. Research has discredited the risk approach, although it is still in widespread use. The risk approach fails to predict who will actually develop complications in pregnancy and delivery. Instead, the WHO package includes a classification form to help providers identify women who have conditions that require treatment and more frequent monitoring.

**Contextual factors**

Traditionally, ANC programmes in Kenya, have mirrored those in developed countries. Too often, however, programmes here are poorly implemented and do little to promote the health of mothers and newborns. Until recently, many of the components of ANC had not been rigorously evaluated. Now WHO has developed a focused ANC package that includes only counseling, examinations, and tests that serve immediate purposes and have proven health benefits.

Several studies have shown that ANC is a vital opportunity to reach pregnant women and their families. Because 88 percent of pregnant women in Kenya receive ANC from a skilled attendant (many of them twice), interventions during these visits have the potential to make a strong impact. The only way this can happen is for each visit to be thorough, comprehensive, and personalized. The service provider must view each visit as if it were the only visit the woman might make. Of those women who attend ANC, at least 41 percent are delivered by skilled attendants within and outside of health facilities. The other mothers are attended at delivery by non-skilled attendants.

The new approach to ANC emphasizes the quality of care instead of the quantity. For normal pregnancies, WHO recommends only four antenatal visits. The major goal of focused ANC is to help women have normal pregnancies and safe deliveries, which results in healthy babies and mothers.

**Objectives**

The objectives of FANC are as follows:

- Identify pre-existing health conditions
- Detect complications early on that might arise during the pregnancy
- Promote good health and disease prevention during pregnancy
• Be prepared for the birth and possible complications

**Interventions**

In order to implement the FANC and IPT of MIP programmes, the following activities were carried out:

• Advocacy and consensus-building among health providers and health administrators at various levels
• Development and production of training materials
• Development and production of orientation packages
• Capacity building: training of service providers
• Supportive supervision
• Clinical mentoring
• Continuous monitoring and evaluation
• Programme evaluation
• Feedback to stakeholders

The FANC/IPT of MIP project was implemented by the MOH of Kenya with bilateral donors and international partners in RH. During the planning stages of the project, the stakeholders engaged in the following activities in order to fully understand and appreciate their roles in the project:

• Advocacy and sensitization
• Consensus building
• Capacity building
• Demand creation
• Documentation
• Monitoring and evaluation (M&E)

**Key stakeholders in the FANC/IPT of MIP programme**

The main stakeholders and the roles they played during the initial phase of the programme were as follows:

• The MOH of Kenya implemented the programme through its various levels of administration and health care delivery. The departments of the MOH were led by the DRH at various levels of care and management.
• The DFID provided the funding for the programme.
• JHPIEGO-ACCESS provided technical support to the MOH at the various stages of the programme. JHPIEGO worked closely with MOH of Kenya at all stages of the programme
The U.S. Centers for Disease Control (CDC) carried out the evaluation of Malaria in Pregnancy (MIP) based on the training of the providers.

The initial phase of FANC was implemented in four sites. JHPIEGO provided the MOH, DRH, and DMC with technical support to implement the FANC-IPT of MIP programme activities. Early in the programme, planning, advocacy, and sensitization meetings were held at the following levels:

- At the central level in Nairobi
- At the regional (provincial) levels in Kisumu
- At the district levels in Kisumu, Thika, and Kericho

As part of the preparatory activities, a situational analysis was carried out to create a baseline in the districts of Kwale, Taita Taveta, Bondo, and Homa Bay.

**Capacity building**

Following the advocacy sensitization workshops, the following capacity-building activities were carried out:

- Adaptation and adoption of training materials
- Adaptation and adoption of orientation packages
- Pre-testing of the training materials in Meru Central District
- Finalization and production of the training materials
- Training of trainers (TOT) for the central-level MOH officials
- TOT workshops for the district MOH staff
- Dissemination of FANC and IPT of MIP control guidelines in 19 districts
- Support of supervisory activity in approximately 25 percent of the health facilities in 17 of the 19 programme districts
- Follow-up survey in the four baseline districts

**Documentation**

Supervisors were responsible for documenting all of the project activities, as part of their role as providers of facilitation and support.

Providers used existing MOH data-collection tools to describe their FANC / MIP activities. The documentation made it possible to share information and to monitor and evaluate the progress and success of the programme based on the initial baseline survey.

**Monitoring and evaluation and operations research**

From the start, monitoring and evaluation (M&E) was considered vital to successfully implementing the initiative and gauging its success. The M&E was crucial in determining the various outcomes of the project. Several indicators were
agreed upon at the onset of the programme and were the focus of internal reviews and a midterm and a final evaluation.

The results of the baseline and endline surveys, which were done in the course of implementing the programme, are summarized in Table 5.

**Table 5. Baseline and endline survey results**

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Baseline survey 2002 (percent)</th>
<th>Endline survey 2003 (percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women receiving at least intermittent prevention and treatment (IPT)—one FANC visit</td>
<td>60</td>
<td>78</td>
</tr>
<tr>
<td>ANC providers receiving updates in RH and MIP</td>
<td>28</td>
<td>53</td>
</tr>
<tr>
<td>Health providers’ knowledge of three or more danger signs in pregnancy</td>
<td>14</td>
<td>76</td>
</tr>
<tr>
<td>Discussions of danger signs between health providers and clients</td>
<td>17</td>
<td>47</td>
</tr>
</tbody>
</table>

The CDC conducted an evaluation of the incidence of MIP following the training of service providers and the sensitization of communities by Access to Clinical and Community Maternal, Neonatal, and Women’s Health (ACCESS) in Nyanza province. The results showed that the use of SP increased in the areas where these interventions were conducted.

**Table 6. Uptake of IPT_1 and IPT_2 in Nyanza Province**

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Asembo 02 percent</th>
<th>Asembo 05 percent</th>
<th>Gem 02 percent</th>
<th>Gem 05 percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPT—one FANC visit</td>
<td>19</td>
<td>61</td>
<td>17</td>
<td>28</td>
</tr>
<tr>
<td>IPT—two FANC visits</td>
<td>7</td>
<td>37</td>
<td>7</td>
<td>11</td>
</tr>
</tbody>
</table>

**Results**

**Training and orientation packages:** The MOH of Kenya, in partnership with JHPIEGO and the DMC, developed the *Focused ANC and Malaria in Pregnancy* orientation package, which has been adopted as the national training standard.
The orientation package is a tool used to update providers and supervisors in FANC and IPT of MIP.

**Roll Back Malaria (RBM) initiative and partnerships:** In order to strengthen the prevention and treatment of MIP, the Roll Back Malaria (RBM) programmes have had to partner with the Making Pregnancy Safer Initiative at the global and regional levels to deliver cost-effective interventions through ANC and programmes that are accessible to the community.

JHPIEGO has worked very closely with the DRH and DMC to improve FANC services targeting the prevention and control of MIP. These targeted efforts have strengthened the capacity of trainers, supervisors, and service providers to deliver FANC services, which has led to improved quality and use of focused ANC services in 22 malaria-endemic districts.

JHPIEGO contributed input to WHO’s RBM Initiative. Kenya was used as a country case study to demonstrate the integration of programmes addressing RH and MIP.

**The Millennium Development Goals:** The FANC/IPT of MIP programme is expected to play a major role in Kenya’s progress towards attainment of the MDGs:

- Evidence-based ANC is being delivered to women in the 22 districts.
- The diagnosis and treatment of malaria has improved in the 22 districts.
- Pregnant women in the 22 districts do generally receive IPT for malaria prevention.

An endline survey involving service providers and pregnant women from antenatal clinics conducted in four holoendemic regions of malaria revealed the following:

- Pregnant women recognized malaria as a common ailment that is bad for the unborn child.
- Spontaneous knowledge of prevention of malaria is high with the use of insecticide-treated nets (ITNs).
- Awareness of danger signs during pregnancy is low.
- ANC clients had a vague perception of the value of ANC.
- Service providers were aware of the consequences of MIP.
- Few clients said in exit interviews that they had received IPT.
- Only about 50 percent of the service providers had seen or were familiar with the National Guidelines for Malaria, including treatment with SP in place of chloroquine.

**Sustainability**

Kenya has adopted the integration of FANC and MIP. The programme is part of the MOH’s annual work plan and annual operation plans. It will benefit from the approach to health care financing of such initiatives as the Sector Wide Approach (SWAP).
Community initiative and partnership was the key to the uptake of services and commodities.

Globally, the sustainability of integrating FANC and IPT of MIP is supported by the various RBM initiatives.

ANC visits can be a wasted opportunity if service providers do not implement FANC, because a majority of women come for at least one antenatal visit.

Sustainability of the FANC package is contingent upon the following:

- Maintaining funding to strengthen ANC services
- Increasing equipment and supplies that are needed to offer these services at clinics providing ANC
- Training providers so that they are fully competent in all the component services, and able to offer them in an integrated fashion
- Ensuring that supervisors are able to support and enable providers to deliver integrated, comprehensive ANC services
- Communicating the new regimen of services and their timing to the general public so that ANC attendance is initiated earlier and in accordance with the four-visit schedule
- Maintaining commitment by the MOH of Kenya and all partners to the intervention programme
- Reviewing policies and guidelines for appropriate financing models that can ensure equity and access to RH and allied services
- Partnering with local stakeholders at all levels of implementation
- Collaborating and leveraging resources

Replicability

The programme has been rolled out in all seven of Kenya’s provinces.
### Table 7. Provinces and districts in which the programme has been rolled out

<table>
<thead>
<tr>
<th>Province</th>
<th>District</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Province</td>
<td>Kirinyaga, Thika</td>
</tr>
<tr>
<td>Coast Province</td>
<td>Kilifi, Kwale, Lamu, Malindi, Mombasa, Taita Taveta, Tana River</td>
</tr>
<tr>
<td>Eastern Province</td>
<td>Meru Central, Embu, Mbeere, Makueni, Machakos</td>
</tr>
<tr>
<td>North Eastern Province</td>
<td>Garissa</td>
</tr>
<tr>
<td>Nyanza Province</td>
<td>Bondo, Homa Bay, Migori, Nyando</td>
</tr>
<tr>
<td>Western Province</td>
<td>Busia</td>
</tr>
<tr>
<td>Rift Valley Province</td>
<td>Kericho, Kajiado</td>
</tr>
</tbody>
</table>

Based on the FANC and IPT of MIP work initiated in Kenya, multiple countries (Tanzania, Burkina Faso, Madagascar, Rwanda, and Zambia) have adopted a similar approach that uses FANC as a platform for the delivery of MIP interventions.

Following the successful implementation of the FANC/IPT of MIP programme, Kenya became a member of Malaria in Pregnancy in Eastern and Southern Africa (MIPESA). This is a coalition of countries (Tanzania, Uganda, Malawi, Kenya and Zambia) and their partners: the WHO, Prema-EU, the United Nations Childrens Fund (UNICEF), CDC, and JHPIEGO.

**Lessons learned**

The introduction and success of FANC/IPT of MIP required the following:

- A collaborative relationship between the national reproductive programme (the implementing agent) and the national malaria control programme (which provides the technical oversight and guidance on malaria issues)
- Competent providers to modify pre-service training curricula in ANC and in-service training in ANC for providers and their supervisors
- Training health care workers to change their attitudes and practices
- Assessment of the changes in drugs, equipment, and supplies needed to provide ANC and planning to introduce these changes
- Infrastructure modifications, including the redesign of the client-care process and the physical space available for ANC, and a functioning laboratory
- Advocacy at the central and district level
- Training staff in new ways to organize and provide services
Given the high staff attrition in sub-Saharan Africa and especially Kenya, it is critical to develop and use training and supervisory strategies that are explicitly designed to address relatively rapid rates of staff turnover. Ideally, this would be through pre-service training. In the short term, this might mean developing the capacity of all clinic staff, or of the supervisor responsible for monitoring ANC services in the clinic. This would ensure that if a trained staff member leaves, the replacement has the same technical competence or undergoes immediate training in the ANC model that is being implemented at that clinic.

Much is still required to make it easier for women to comply with the timing of FANC visits. It is clear that what induces pregnant women to change their ANC service use could be more than just a reduction in the number of visits. FANC is a scheduled service, and when clients do not adhere to the recommended timing, the service’s effectiveness is challenged.

**Challenges**

The main challenges encountered in the intervention appear below:

- The weak health care system, which does not meet the needs of women to address the critical issues in safe motherhood, including MIP
- Analyzing, synthesizing, and disseminating critical experiences and research findings and their implications to policy makers for policy formulation and implementation
- The contentious area is the role of SP in relation to IPT and malaria case management
- Lack of clarity among service providers in terms of preventing MIP in the context of drugs policy change
- Lack of institutionalized, regular support supervision for reinforcement and maintenance of gains made in various RH programmes
- Finding ways to encourage patients to deliver in the hospital or alternative settings where the patients can be delivered with the assistance of skilled attendants
- The lack of resources in the FANC/IPT of MIP programme to provide basic training to Medium level medical personnel and medical students
- Lack of appropriate health care financing that is equitable and supports poor people

**Recommendations**

Some of the recommendations made from Phase I of the project are listed below:

- Leverage local funding from other agencies, and lobby the government ministry of finance to have a budget line sufficient for RH.
- The programme must remain flexible and responsive to lessons learned, new evidence, and recommendations.
• Provide FANC, including individualized birth-preparedness counseling regarding the place of delivery. This increases the chances of a woman delivering in a health unit.

• Develop user-friendly information, education, and communication (IEC) materials and interventions, and disseminate them to the frontline workers to improve FANC and IPT of MIP.

• Make every effort to introduce PMTCT and PTB screening and care into ANC.

• Encourage innovative approaches to enable women to deliver with skilled birth attendance.

• Strengthen the gains made while finding ways to overcome existing challenges.

• Advocate at the central and district levels to increase the likelihood of uptake and success of any programmes.

• Implement training to change the attitudes and practices of health care workers.

• Maintain regular support supervision to reinforce and sustain gains.

• Keep programmes flexible as evidence is gathered globally and WHO changes its recommendations on various practices. The lessons will be used to inform the proposed National Social Health Insurance Scheme.

• Institutionalize data collection, and possibly sentinel surveillance.

• Scale up MIP intervention in all malaria-endemic districts.

• Expand the FANC/IPT of MIP programme to include training, procurement of drugs and supplies, service delivery, supervision, and monitoring and evaluation.

• Improve the training and deployment of skilled attendant cadres.

References


2. Repositioning the Intrauterine Contraceptive Device in Kenya

Background

Kenya has seen an improvement and subsequent decline in reproductive health and maternal and child health indicators over the past several decades. The contraceptive prevalence rate (CPR) for all methods among married women rose from 10 percent in 1984 to 39 percent in 1998. It reached a plateau between 1988 and 2003, indicating a significant unmet need for family planning (FP). In the mid-1990s, Kenya was faced with a highly skewed and unsustainable contraceptive method mix. By 1998, DMPA accounted for almost 40 percent of modern methods, while pills, the intrauterine contraceptive device (IUCD), and sterilization were in decline. Despite IUCD safety, effectiveness, convenience, and low cost, the percentage of women in Kenya who used IUCDs for contraception dropped from 21 percent in 1989 to 7.6 percent in 2003.

The underusage of IUCDs and other long acting and permanent methods (LAPMs) became a cause of concern to the Kenyan government and health-policy makers. Over reliance on relatively expensive methods burdened Kenya’s FP programme, which was already faced with budget cuts as resources were increasingly directed to HIV/AIDS programmes, and limited women’s access to a full range of contraceptive options.

Research showed that a combination of factors contributed to this decline in the uptake of methods such as the IUCD. Among these factors are poor quality of care, fear of HIV transmission, misconceptions and myths about IUCDs, provider bias or preference (e.g., concerns about the time and skill required to offer IUCDs), shifting client preferences, lack of expendable commodities, and the availability of Norplant and DMPA. In 2001, the MOH of Kenya was encouraged by recent findings on the safety of IUCDs. In collaboration with several local and international partners, the ministry launched an initiative to promote a balanced and sustainable national FP programme, increase client choice, and reintroduce the IUCD into the Kenyan contraceptive method mix.

Rationale

The IUCD is a low-cost, long-term contraceptive. Decades of research attest to its safety and effectiveness. In low-resource settings such as Kenya, this method has many benefits. Recent research has shown that it is safe even for women who are HIV-positive. Because of this evidence of the IUCD’s safety, effectiveness, and low cost, an initiative was launched to reintroduce the IUCD into the contraceptive mix.

Contextual factors

The reintroduction of the IUCD was initiated against the background given above. At the same time, Kenya was undergoing serious challenges in ensuring FP commodity security, with recurrent stockouts. HIV/AIDS was taking all the focus by all the players, including the bilateral partners. It became necessary to reintroduce a method whose safety and cost benefits were well established even in the era of
HIV/AIDS. The refocus and reintroduction of the method would address the issues of method mix and cost, while ensuring long-term use by clients.

**Objectives**

The objectives of this initiative were to:

- Increase support for the IUCD among policy makers, service providers, and clients
- Increase the quality IUCD services
- Enhance demand for IUCDs
- Monitor and evaluate programme performance

**Interventions**

The process of identifying factors that affect IUCD use and building consensus among stakeholders occurred in several steps over the course of approximately two years:

1. In early 2001, the MOH of Kenya and FHI hosted a panel session at the annual meeting of the Kenya Obstetrics and Gynecological Society (KOGS) to discuss IUCD usage in Kenya. The members agreed that there was a need to convene a national stakeholders meeting to discuss matters related to the IUCD.

2. Several months later, FHI organized a stakeholders meeting to bring together government leaders, representatives from nongovernmental organizations, and providers. The meeting served as a venue to present the most current IUCD research and to discuss a way forward. The stakeholders proposed the formation of the IUCD Task Force, which the MOH of Kenya adopted.

3. In March 2002, the task force — with the MOH as chair and FHI as secretariat — met to develop a revitalization strategy and work plan for the reintroduction of IUCDs. In subsequent quarterly meetings, the group developed a work plan outlining goals, activities, indicators of success, and a timeline.

4. The National IUCD revitalization strategy was launched at the annual conference of the East, Central, and Southern African Association of Obstetrical and Gynecological Societies (ECSAOGS).

5. The IUCD Task Force transitioned to a more streamlined implementing body under the chairmanship of the Department of Reproductive Health (DRH) within MOH. The DRH adopted a systematic approach of quarterly meetings and regular progress reports. The MOH led this group, which consisted of representatives of the MOH, FHI, AMKENI, JHPIEGO, and several medical professional associations.

The IUCD revitalization strategy consisted of five general categories of activities, which are detailed below.
Advocacy and sensitization

Based on research findings about the causes of declining IUCD use, the task force recognized that the revitalization strategy would require a strong advocacy component to combat provider bias and misinformation. FHI was responsible for developing the advocacy strategy. Throughout the process, FHI maintained strong partnerships with professional organizations and local nongovernmental organizations whose members work closely with providers or are providers.

Advocacy and sensitization activities included the following:

• The MOH of Kenya, with the task force’s assistance, revised the *Kenya Family Planning Guidelines for Service Providers*, which now includes the new medical eligibility criteria for the IUCD and all other contraceptive methods.

• A call-in radio programme featured IUCD advocates, satisfied users, and providers.

• A package of IUCD advocacy briefs targeting providers and policy-makers was developed by MOH of Kenya, FHI, and representatives from all the major medical professional associations in Kenya. In non-technical language, these briefs addressed the issues of concern identified in the IUCD assessment and stakeholders meeting: safety, efficacy, cost, convenience for clients and providers, eligibility criteria, and potential as a safe method for HIV-positive women.

• The MOH hosted district-level meetings of public-sector providers, health facility managers, and policy-makers in all eight provinces. The purpose of the meetings was to disseminate the revitalization strategy and the briefs and to review information about the IUCD.

• Private-sector providers across the country were invited to sensitization meetings as part of their continuing professional development (CPD). Participants were certified and the sessions were recognized as part of their CME by their respective professional bodies. The CPD materials were adapted and used to train pre-service trainers from universities and medical training colleges.

Capacity building and service delivery

Capacity building and service delivery were primarily implemented by MOH teams and the USAID-funded, Engender Health-led AMKENI project, which works to improve RH service delivery at 97 MOH-supported sites in Kenya’s Coast and Western provinces. To fit the revitalization effort into AMKENI’s work plan, pilot facilities were selected from these two provinces. Their activities included the following:

• With leadership from AMKENI, MOH of Kenya and the rest of the IUCD task force revised the national RH curriculum. Previous training materials were piecemeal and out of date. The new curriculum was standardized, with updated information about reproductive health and FP.

• AMKENI held facility-level orientation meetings to introduce IUCD revitalization in 10 districts in Coast and Western Provinces. These meetings
included the entire staff of the facilities, not just the providers. This provided all
the staff with an opportunity to understand the programme and their future roles
in it.

• AMKENI provided clinical, in-service training and refresher courses to public and
private providers in eight districts on all aspects of IUCD service provision.

• AMKENI distributed nearly 600 kits for IUCD insertion and removal to trained
providers and it continues to work with the USAID-supported DELIVER project
of John Snow, Inc., to make sure sufficient numbers of IUCDs and related
supplies are available at the facilities.

• FHI developed a checklist to help providers determine if clients are medically
eligible to use the IUCD. The checklist was partially field-tested in Kenya. During
four focus-group discussions with providers, Kenyan providers reviewed and
endorsed the use of the checklist.

The MOH of Kenya’s newly-formed, decentralized, RH training and supervision
teams continue to provide supportive supervision. Their goal is to ensure that
facilities have sufficient training, commodities, and supplies to offer IUCDs to their
clients.

**Demand creation**

The IUCD suffered from a poor reputation among FP clients, who were rarely
offered the method and often discouraged from using it by persistent rumors about
its safety and by providers’ attitudes. The providers’ attitudes were influenced by
many factors: infrastructure, provider skills, equipment, and supplies. The task force
(mostly implemented by AMKENI) undertook a campaign in AMKENI’s two focus
provinces to dispel myths and to inform potential clients about the benefits of the
IUCD and all modern FP methods.

Under FHI leadership, task force members developed two brochures (each produced
in English and Swahili) for clients of RH services. One brochure discusses the IUCD
— explaining what it is, who can use it, and its benefits and side effects. The other
brochure provides information about all modern FP methods, including the IUCD.

AMKENI incorporated a new IUCD emphasis into its existing Behavior Change
Communication (BCC) programme. They trained more than 500 BCC agents, mostly
volunteers who live in the communities they serve, to provide information about the
IUCD and FP in general. The BCC agents met with village health committees,
women’s groups, men at worksites, youth groups, and families. They distributed the
IUCD and general contraception pamphlets.

**Documentation**

The process of documenting all the activities of the project was put in place as part of
facilitative support supervision. Data and information was available in the
implementing facilities. The documentation enabled participants to share
programme information and made it easy to monitor and evaluate the progress and success of the programme based on the initial baseline survey.

**Monitoring and evaluation and operations research**

From the start, monitoring and evaluation (M&E) was considered vital to implementing the initiative and gauging its success. FHI was designated to lead the M&E process. During the M&E planning, FHI put measures in place to ensure appropriate documentation of all activities throughout the life of the project. These measures included the following:

- FHI developed an M&E plan that listed project objectives and the activities required to meet them, indicators to be measured, target goals, and the partners responsible for collecting data on progress.
- FHI coordinated and documented the IUCD task force meetings and prepared quarterly reports with updates on progress and results.

AMKENI is collecting data in two provinces about the increase in IUCD users, which will be an important indicator of success. To assess national-level data, the DELIVER project will report on the current supply of IUCDs, which will show how many have been provided to clients.

**RESULTS**

**Sustainability**

The fact that the strategy has been mainstreamed in the MOH FP programme enhances its sustainability.

**Increased utilization of the IUCD**

In the AMKENI project, which ended in 2005, the number of new users in the 97 facilities supported by AMKENI increased from 151 per quarter at baseline in early 2003 to 373 per quarter in early 2005. The cumulative number of IUCD users in AMKENI sites over the two-year intervention period was approximately 2800 women. The Amua project which is a social franchising project targeting the rural private sector with particular emphasis of LAPMs, conducted in the Rift Valley from 2004 to 2007, and the Acquire project which was a project managed by Engender health which employed supply and demand side interventions, conducted in Kisii from 2005 to 2006, both showed notable rises in IUCD uptake.

**Replicability**

The model on which the programme was executed has been replicated both locally and internationally.

- The AMUA and ACQUIRE projects used the IUCD re-introduction strategy (model) to increase the usage of IUCDs.
• The Population Council adopted and produced 500 copies of the IUCD advocacy kit for Ghana Health Services (GHS; i.e., Ghana MOH) at a cost of approximately USD 1500.

• GHS used advocacy kits to help sensitize 153 FP programme managers and service providers.

• India is borrowing the Kenya strategy to develop its own strategy to re-introduce the IUCD.

Lessons learned
The following lessons were learned in the course of implementing the programme:

• Building activities on evidence (especially synthesis and discussion of local evidence) is more effective.

• Programme commitment to intervention by the MOH of Kenya and all the partners is critical for sustainability.

• Review of policy and guidelines to ensure appropriate content is necessary.

• Partnerships with local stakeholders at all levels of implementation is critical.

• Community initiative and partnerships are key to service and commodity uptake.

• Collaboration and leveraging of resources is feasible.

Challenges
During the course of implementing the programme, several challenges were encountered:

• Weak health infrastructure

• Bureaucracy in the decision-making process of government agencies

• Inadequate and erratic supplies of commodities

• Inadequate support by providers

• Competition from other short-acting contraceptives (e.g., DMPA)

• Lack of continuity in facilities’ commitment to the IUCD and provision of IUCD services

• Insecurity among clients that the services will be maintained

Recommendations
The recommendations listed below should be followed to successfully reposition the IUCD in Kenya:

• Partners and stakeholders who support the MOH of Kenya should work within the ministry’s existing structures.

• Stakeholders on a project should consult with each other regularly.
• Encourage advocacy, sensitization, and consensus building.
• Maintain regular supportive supervision.
• Advocate for inclusion of the project into the annual operating plan (AOP) of the MOH.
• Advocate for a line in the MOH’s budget covering all the components of IUCD services to ensure that they will be continuous.

References
3. Integrating Family Planning into Voluntary Counseling and Testing Centers in Kenya

Background

In Kenya, as in most countries, FP services and HIV voluntary counseling and testing (VCT) services have traditionally been offered separately. Health policy makers, however, have begun to recognize the opportunities missed and efficiencies lost in this parallel approach. Family planning plays an important role in HIV/AIDS prevention, and VCT can reach sexually active clients who do not typically seek FP services, such as men and adolescents, as well as HIV-positive women who wish to prevent unwanted pregnancies.

After studies showed that the integration of services in Kenya was feasible, the MOH of Kenya charged FHI and various partners with determining the best way to implement integration of FP in VCT across the country. A subcommittee was established under the leadership of the MOH of Kenya. The other members of the subcommittee were implementing partners, including FHI. This subcommittee developed the strategy of integrating FP and HIV services.

Contextual

There is well accumulated evidence that contraception is potentially a powerful and cost-effective HIV prevention strategy, enabling HIV-infected women to prevent undesired pregnancies, thereby averting mother–to-child HIV transmission. One strategy for extending the benefits of contraceptive services is to integrate the services into HIV/AIDS services like VCT. Based on research findings about the feasibility of integrating family planning services into the Voluntary Counseling and Testing (VCT) in Kenya, the MOH developed a national strategy on integration.

Rationale

Emerging evidence from research findings indicates that integrating FP into VCT services is acceptable and has the potential not only to improve the quality of care, but also to help prevent mother-to-child transmission (PMTCT) of HIV. As the integration of FP into VCT was being implemented, it became increasingly important to assess the performance of this form of intervention and prove the value it adds to VCT services.

Objectives

The objectives of this integration were as follows:

• Determine the effectiveness and costs of adding selected levels of FP services to VCT centers.
• Determine the effect of adding FP services to VCT services on the quality of the VCT services.
• Conduct a feasibility study on FP/VCT.
This study was conducted by FHI in Kenya after the Kenya MOH VCT committee indicated it needed local evidence generated to allay the fears that were expressed then about the acceptability and the possible effect on the quality of VCT if FP services are integrated in it.

The feasibility assessment revealed that the clinical backgrounds of VCT providers varied widely and were associated with the type of facility in which they worked. Providers in larger health facilities had more clinical training and were more likely to be able to provide FP services than did providers in stand-alone facilities. Providers at these smaller facilities were less likely to have a robust referral network. Feedback from the sensitization meetings corroborated the assessment’s findings that VCT sites varied significantly in their readiness to integrate services. Some lacked necessary equipment and supplies, while others lacked space and staff.

**Interventions**

After being presented with the integration feasibility study’s positive results, the Main VCT Committee of the National AIDS and STI Control Programme (NASCOP) immediately formed a subcommittee on FP and VCT to develop a national integration strategy. The subcommittee was composed of VCT and FP experts from NASCOP (subcommittee co-chair), the DRH (co-chair), FHI (facilitator), JHPIEGO, AMKENI, the U.S. Centers for Disease Control (CDC), Kenya National Hospital, Kiberia Integrated Community Self-Help Programme (KICOSHEP), and the National Leprosy and Tuberculosis Programme (NLTP). Based on the feasibility of FP into VCT study’s findings, the subcommittee developed a strategy for integrating FP into VCT and vice versa. Integration was defined as “the incorporation of some or all of the different FP services into existing VCT services and vice versa.”

The group decided, however, to first concentrate on integrating FP into VCT, and they developed a strategy flexible enough to allow each VCT site to determine the degree of integration that was possible, based on its resources and capabilities. At all sites, the strategy involved assessment of risk for STIs and unintended pregnancy, provision of counseling on contraceptive methods, and referral for methods not available at the VCT centers.

The sites differed, however, with respect to the contraceptive methods they are equipped to provide, as categorized by the following levels:

- **Level I**: condoms and pills
- **Level II**: condoms, pills, and injectables
- **Level III**: condoms, pill, injectables, and IUCDs
- **Level IV**: a full range of contraceptives

The strategy recommended that all VCT centers achieve at least Level I. Level IV was viewed as a long-term goal. Key activities that would be necessary to achieve integration included:
• Achieving consensus and commitment among programme implementers
• Building the capacity of VCT programmes to provide FP services
• Creating awareness and demand for FP services among target-VCT population
• Developing, monitoring, and evaluating initiatives to assess effectiveness and ensure sustainability of the programmes

• The subcommittee presented the strategy to the main VCT committee, which gave its approval.

Subcommittee members agreed that the most effective way to build support for integration was to work through the MOH of Kenya’s existing administrative structures. The subcommittee held sensitization meetings in all eight provinces with the MOH’s top provincial- and district-level medical personnel: doctors, nurses, health administrators, and RH and HIV coordinators. The subcommittee presented the strategy, requested feedback, and asked attendees what challenges they expected their provinces and districts to face in integrating FP into VCT services.

Capacity building
In order to target those providers who would be in a position to put their new skills into practice, the MOH of Kenya required the subcommittee to conduct pre-training site assessments to identify VCT sites that demonstrated a high workload, low staff turnover, ample and consistent supply of FP commodities, and a readiness to integrate. Voluntary counseling and testing counselors from these sites were then selected to participate in the integration training.

Documentation
Training materials: Independently of each other, JHPIEGO and Engender Health/AMKENI took the lessons learned from the feasibility study and started developing VCT training materials. JHPIEGO developed an orientation package about FP/VCT integration for non-clinical FP/VCT providers, and AMKENI created an integration training manual geared toward clinical providers.

The two manuals covered information on:
• Benefits of integration
• Different levels of integration
• Assessing clients’ risk for unintended pregnancy
• Counseling issues related to HIV and contraception
• Reproductive physiology
• Contraceptive methods with an emphasis on condoms and dual method use
• Helping clients make informed choices
Training and supportive supervision: In November 2004, the subcommittee trained 18 RH and VCT trainers of trainers (TOTs) from four provinces. A month later, eight of these TOTs (four of whom specialized in reproductive health and four in VCT), under the supervision of master trainers, trained 39 VCT providers from the same four provinces. Feedback from those involved in the training indicated that the process of using two manuals was cumbersome, that there was substantial overlap, and that one or the other manual included key elements important for all providers. At the request of the DRH and NASCOP, the subcommittee began combining the manuals.

The new consolidated manual was subsequently used to train more trainers and providers in the scale-up phase of the project in March 2005. The manual, entitled *Family Planning Training for Voluntary and Testing Providers: An Integrated Approach to Counseling and Service Provision*, came in two versions: one for trainers and another for participants. In March 2005, the MOH and JHPIEGO provided supportive supervision of newly trained providers to ensure that they were implementing the integration principles they had learned.

FHI brochure to create awareness about and demand for FP services: The feasibility study which was a formative study to find out the acceptability of FP/VCT integration, indicated that VCT clients were open to receiving FP services at VCT centers. To further inform clients about FP services and the benefits of receiving those services at VCT centers, FHI produced a client brochure in collaboration with the integration subcommittee. Produced in Kenya, the brochure encourages VCT clients to consider their FP needs and to discuss them with their VCT counselor.

Monitoring and evaluation and operations research

In April 2005, five months after the first providers were trained in integration, FHI interviewed clients, providers, and facility managers, and they observed client-provider sessions to document the extent of the integration. At this point, the number of sites eligible for the study declined from 20 to 14, because the MOH of Kenya determined through the pre-training site assessments that six of the original 20 sites were not eligible. To assess the effectiveness of the intervention, four indicators were measured.

Provider knowledge and attitudes: It is important to know whether the intervention improved the FP knowledge and attitudes of VCT providers, because these are key precursors to behaviour change among clients.

Provision of FP services: To evaluate the FP services provided in VCT, researchers relied on managers’ in charge, provider and client reports, and observations of client-provider interactions.

Referrals: Because it is not realistic to expect all FP services to be available in VCT facilities, research also documented any improvements in referral practices.

Demand for contraception: Researchers measured client demand and potential client demand for contraception by assessing the clients’ risk of unintended
pregnancy, noting whether or not providers were adequately identifying clients in need of contraception, and observing whether clients accepted FP methods and referrals from VCT providers.

Because VCT provides a unique opportunity to reach men, indicators were also compared by gender to assess whether pregnancy-prevention messages were being provided to men as well as women. Another objective of the study was to monitor the quality of VCT to ensure that introducing FP into VCT did not compromise the quality of VCT services. The quality of VCT was monitored mainly through observations of interactions between clients and providers.

**Results**

The results of the surveys are provided in Table 8.

**Table 8. Results of the surveys**

<table>
<thead>
<tr>
<th>Baseline Survey/End-line Survey</th>
<th>Pre-intervention Survey</th>
<th>Post-intervention Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider discussed pills</td>
<td>12</td>
<td>43</td>
</tr>
<tr>
<td>Provider discussed injectables</td>
<td>11</td>
<td>36</td>
</tr>
<tr>
<td>Male and female sterilization</td>
<td>5</td>
<td>24</td>
</tr>
<tr>
<td>Client chose a method</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Provider gave a method</td>
<td>17</td>
<td>29</td>
</tr>
</tbody>
</table>

Findings of the OR included the following:

- Clients who attended VCT received information and a variety of contraception methods, confirming that it is feasible to integrate FP into VCT services.
- Providers’ knowledge of FP increased as a result of the intervention, as did the likelihood that VCT clients would receive FP messages during counseling and testing.
- The quality of VCT services, measured by the length of the session and client perceptions, was not negatively affected by the introduction of FP.

**Sustainability**

The fact that the concept of integrating FP into VCT services was supported by the Kenya MOH and mainstreamed in the MOH decentralized structure of training and supervision ensures sustainability.
Replicability

The subcommittee trained an additional 20 trainers, some of whom worked with subcommittee members to train 61 more VCT providers. During the original intervention and scale-up, training was provided to a total of 38 TOTs and 101 providers who represented all eight provinces in Kenya.

In addition to USAID, the President’s Emergency Plan for AIDS Relief (PEPFAR) provided funding for training. This resulted in more sites providing FP/VCT services. This is a bilateral project between USAID and the Kenya Government that supports the delivery of integrated HIV and RH services across the provinces. Currently, APHIA II projects are also involved in the scale-up activities. Other countries, such as Nigeria and Rwanda, are embracing a similar model of FP/VCT.

The following factors were key to the success of the intervention:

- Government leadership
- An effective commitment by stakeholders
- The involvement of the various line ministries, which can encourage the partners to work with a sense of purpose. This will ensure that certain activities are carried out quickly. For example:
  - Development of a national strategy and guidelines on integration
  - Appropriate pre-training site selection
  - Appropriate TOT and service provider trainings
- Support from the administrations of the implementing health facilities

Lessons learned

The following lessons were learned during the course of the project:

- Integration of services allowed for more comprehensive services and expanded access.
- Integration of services improved the cost effectiveness of providing services.
- Establishment of technical working group on integration, chaired by NASCOP and the DRH, was necessary for implementation to take place within the MOH structures.

Challenges

The challenges to integrating services involved the following:

- Gaining acceptance and ownership of the process
- Harmonisation of the integration training materials
- Overcoming FP commodity insecurity
- Difficulty in measuring integration
**Recommendations**

The following recommendations are based on the results of the intervention:

- Make efforts to integrate FP and RH in all HIV services to achieve total integration.
- Scale up integration efforts.
- Continue to generate and share evidence on the provision of integrated services.
- Continue to support the MOH of Kenya in its integration efforts.
- Ensure measurement of integration indicators.

**References**


4. Kenya Adolescent Reproductive Health Programme (KARHP)

**Background**

The Kenya Adolescent Reproductive Health Project (KARHP) was initiated in 1999 by FRONTIERS and the Population Council in partnership with Partners for Appropriate Technology in Health (PATH) and it was first piloted in two districts (Busia and Vihiga) in Western Province in Kenya. The KARHP was part of FRONTIERS’ four-country Global Youth Study (conducted also in Senegal, Bangladesh, and Mexico). This study tested a multi-sectoral approach to improving young people’s reproductive health knowledge and behaviour at community, school, and health facility levels in the two pilot districts. The intervention involved the ministries of Education, Science, and Technology (MOEST); Health (MOH); and the Ministry of Gender, Sports, Culture, and Social Services (MGSCSS). Community leaders, parents, and youth provided input.

As in the other countries (Bangladesh, Senegal, and Mexico), the project used the quasi-experimental design using pre- and post-intervention testing. Researchers compared the reproductive health knowledge and behaviour of control groups, who received no intervention, to that of experimental groups, who received the interventions from school-based education. The researchers used a life-skills curriculum that included reproductive health, clinic-based, youth-friendly services in designated spaces, and community outreach and mobilization to encourage a supportive environment for youth.

**Rationale**

The KARHP was launched in Western Province against a backdrop of poor reproductive health indicators and a poor policy and legislative environment for adolescent reproductive health issues. No systematic reproductive health education programmes were in place for in- and out-of-school adolescents. Controversy around providing services to sexually active adolescents was common, and a pervasive concern that sex education and contraceptive services would lead to promiscuity prevailed. Cultural sensitivities about adolescent sexuality made it difficult for communities to discuss the subject, and researchers encountered strong religious opposition.

**Contextual factors**

The KARHP was implemented by PATH, the U.S.-based Population Council, and FRONTIERS over three years (October 1999 to March 2003) in two rural districts in western Kenya. Focusing on in- and out-of-school youth between the ages of 10 and 19, the project aimed to delay the onset of sexual activity, decrease and prevent high-risk sexual behaviours, and increase adolescents’ knowledge of reproductive health and their uptake of reproductive health services. In order to achieve these ends, partners developed a strategy that included peer education, guidance and counseling in schools, and introduction of youth-friendly services in participating health facilities. Sensitization and guidance efforts conducted by trained peer educators in community-, clinic-, and school-based interventions were the hallmark of this programme.
Objectives
The specific objectives of the programme were to:

• Improve knowledge about reproductive health and encourage a responsible and healthy attitude towards sexuality among adolescents
• Delay the onset of sexual activity among younger adolescents
• Decrease risky behaviours among sexually active adolescents

Interventions
The community-based interventions included:

• Promoting parent-child communication
• Training peer educators
• Training and capacity building for project partners from the community (selected from churches of various denominations)
• Bringing religious leaders and peer educators together to ensure that adolescent sexual and RH (ASRH) messages were delivered to parents and youth

The health-facility based interventions included the following:

• Providers from public and private health facilities were trained to deliver youth-friendly RH services.
• The facilities established a separate facility (youth-friendly rooms) within the health center where youth could meet with service providers and obtain information and services. Youth-friendly rooms were stocked with IEC materials, and peer educators were available.

School-based intervention included the following:

• Peer education, guidance, and counseling
• Referrals for health services
• Implementation of a 34-hour Life Skills curriculum
• Providing adolescent RH-training to teachers who were skilled in counseling
• Outreach activities carried out by peer educators who were trained in adolescent RH

Multi-sectoral approach: To implement the project, FRONTIERS collaborated with PATH and three government ministries: Education; Health; and Gender, Sports, Culture, and Social Services. Each ministry took a lead in implementing one of the three interventions that addressed a particular aspect of ASRH. The design goal was to maximize the use of existing government structures, networks, and systems in order to minimize the level of external resources needed. The project was implemented through existing public institutions and used existing community resources (religious and cultural structures and activities). Staff of government ministries participated in all phases of the design, integration, and implementation of ASRH components. Youth, community, and religious leaders were key actors in
providing information and discussing sensitive issues. Costing of pilot interventions made it possible to estimate budgets required to implement ASRH activities within the public sector.

Comparisons of the pre- and post-intervention surveys showed that the multi-sectoral, multi-disciplinary approach succeeded in leveraging resources and also improved acceptance and ownership of the process.

The interventions focused on the following:

- Creating a supportive environment within which information and services could be delivered by working directly with the local communities
- Meeting adolescents’ needs for RH information and services by increasing access within health facilities
- Educating in-school adolescents about SRH within a framework of information about life skills and development

Table 9. Interventions and activities carried out by each partner

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Implementing partner</th>
<th>Target group</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Creating a supportive environment for addressing adolescent sexual reproductive health and rights</td>
<td>Ministry of Gender, Sports, Culture and Social Services</td>
<td>Local chiefs, Religious leaders, Women’s groups, Youth groups, Out-of-school youth, Parents, Social development agents</td>
<td>Public meetings (Barazas), Sports, Songs and drama, Peer education, Video shows, Public debate, Church sermons</td>
</tr>
<tr>
<td>2. Meeting the information and service needs of sexually active adolescents</td>
<td>Ministry of Health</td>
<td>Doctors, Clinicians, Nurses, Public health technicians, Young people</td>
<td>Setting up youth-friendly rooms, Provision of IEC materials, Counseling, Medical treatment</td>
</tr>
<tr>
<td>3. Educating in-school adolescents</td>
<td>Ministry of Education</td>
<td>Guidance counselors and teachers, Peer educators, Students, Head teachers, Parent Teachers Association (PTA), School management committees</td>
<td>Peer education, Face-to-face counseling, Debating clubs, Essay competitions, Sports competitions, Songs, skits, and drama, Educative video shows, Question boxes</td>
</tr>
</tbody>
</table>
FRONTIERS then provided technical assistance to help the ministries incorporate the selected activities into the routine procedures of their staff throughout the two pilot districts and coordinate the work of all three ministries. The following activities were vital to the process:

- Formation of an inter-ministerial coordination group to guide the expansion of KARHP activities throughout Western Province. This group facilitated networking within and among the ministries, reduced duplication of effort, and helped leverage technical and financial resources.

- Training. The implementation used a cascade approach, creating cadres of master trainers at national and provincial levels. FRONTIERS and PATH shared costs with the ministries for training community-level staff, public health and clinical staff, and school personnel at one-third of the schools.

- Incorporation of ARH in ministerial work plans. The MOH, MOEST, and MGSCSS incorporated ARH into their work plans and staff performance requirements. The MOEST took over cascade training for ministry staff, including sensitizing head teachers and school management committees, incorporating life-skills education within school curricula and inter-school KARHP activities (games, dramas, and competitions), and monitoring these activities. The MGSCSS absorbed the monitoring tools and took over community activities, while the MOH adopted the training manuals and conducted multi-sectoral collaboration with other ministries and stakeholders in its reproductive health interventions. Recently, the Ministry of Youth Affairs (MOYA) adopted the life-skills curriculum and monitoring tools for use in youth polytechnic schools.

- Regular monitoring of programme activities. Monthly reports by local-level ministry staff (guidance counselors, teachers, social development assistants, and public health officers) were collected at the district level, entered into a database, and collated into quarterly reports that were discussed at the inter-ministerial meetings. A management information system (MIS) was developed to allow the ministries to track KARHP activities and progress toward set goals. Routine participation in implementation and monitoring allowed the ministries to plan, budget, and leverage support for the activities.

- Cost- and resource-sharing. Inter-sectoral committees were created at district and provincial levels. During quarterly meetings the participating ministries shared experiences and planned jointly for future budgeting and implementation.

- Advocacy. To secure support from the top government levels for scale-up activities in the province, FRONTIERS and PATH initiated and sustained advocacy dialogue with senior staff at various levels of the three ministries. They conducted regular briefing meetings to discuss programmatic, financial, and policy aspects of ministry activities during all phases of the institutionalization, replication, and scale-up.

Experience from the pilot and institutionalization phases was used to refine project tools and streamline the process of replication in other districts in Western Province. Between 2005 and 2006, the three ministries expanded KARHP education,
community, and health activities and tools into the six remaining districts. Over the course of expansion throughout Western Province, the master trainers trained over 1,100 teachers, community workers, clinical and community health technicians, and other ministry personnel. By early 2006, the Tuko Pamoja curriculum had been approved for use in RH education throughout Western Province.

**Inputs for increased service utilization**

This phase focused on strategies to create demand for the programme and an upward trend in the uptake of services. The KARHP achieved these goals through drama, community theatre, and other forms of outreach. Quality was ensured by improving the capacity of providers through trainings and meeting their information, education, and communication (IEC) needs. Activities also succeeded in encouraging healthier behaviours and creating a supportive environment for sexually active adolescents at both the facility and community levels. At the facility level, youth-friendly rooms were created to provide services to the youth. Various consultative and educational meetings were held with key people and groups in these communities (religious leaders, chiefs, youth groups, women groups, and parents).

**Monitoring and evaluation**

The operations research study was conducted between 1999 and 2003. It used a quasi-experimental design to determine the relative effectiveness and cost of the intervention. The two districts of Vihiga and Busia were selected because district authorities there had identified ARH concerns as a priority. The authorities had become concerned about high incidence of sexually transmitted infection (STI), including HIV/AIDS, teenage pregnancy, dropping out of school, and drug abuse.

**Baseline and endline surveys:** Three locations (at the lowest administrative level of government) were selected in each of the two districts and labeled A, B, or C at random. In Site A, two interventions were introduced: a community intervention to create a supportive environment and a health-facility intervention to strengthen the health system’s ability to meet the RH information and service needs of adolescents. In Site B, all three interventions (community intervention, health-facility intervention, and school-based intervention) were introduced. Site C functioned as a control site and had no intervention activities. Baseline and endline surveys were conducted in all sites in both districts.

**Results**

The results showed an increased knowledge and awareness of RH issues, changed attitudes regarding adolescent sexuality and RH, and changes in sexual behaviour.

The results indicated an increased knowledge and awareness in these areas:

- Awareness of basic sexual and RH functions increased substantially among younger adolescents.
- The endline survey showed that awareness of specific STIs among all adolescents was significantly higher in both intervention sites than in the control site.
The following changes in attitude towards adolescent sexuality and RH were noted in the results:

- Disapproval of premarital sex and childbearing was high, and the interventions (especially at Site A) have reinforced these attitudes, including the higher levels of disapproval in females.
- Among boys in Site B, there was no increase in approval of contraceptive and condom use. For boys in Site A and the control site, however, approval increased significantly.
- Among girls, approval of adolescents using condoms increased in both intervention sites. Girls’ approval of contraceptive use by married couples increased in Site A and the control site.
- For those adolescents directly participating in the school-based activities, approval of contraceptive and condom use was significantly lower than for all other adolescents.

The following changes in sexual behaviour were noted:

- Older girls and boys reported higher incidences of penetrative sex in Site A and in the control site. Boys in Site B reported significantly lower incidences of penetrative sex.
- Adolescents participating in the school-based activities reported lower incidences of sexual activities than adolescents who were not exposed to the school-based intervention.
- Age at first sex showed statistically significant delays after the interventions among boys in Site A and Site B and among girls in Site B, but no change in the control site.
- The rate of increase in the proportions of boys and girls becoming sexually active as they get older was significantly lower in Site B than in Site A and Site C at the endline.
- There were decreases over time in the proportion of unmarried girls who reported ever having been pregnant, and these were significant in Site A and the control site.

**Sustainability**

The KARHP ensured sustainability through institutionalization, scale-up, and replication. During the revision and adaptation phase, FRONTIERS and PATH helped the three ministries to identify a package of cost-effective ARH strategies from among those tested during the pilot project that would be suitable for institutionalization in the two pilot districts (Vihiga and Busia).

**Replicability — from pilot to scale-up**

The KARHP was launched in 1999 with pilot projects in two districts (Vihiga and Busia) in Western Province in Kenya. To date, the model has been scaled up in the
provinces of Nyanza, Eastern, Central, and Nairobi. The multi-sectoral model is now used by APHIA II partners in all provinces in Kenya.

With funding from USAID and PEPFAR, FRONTIERS initiated follow-on projects in Kenya (2003-2008) and Senegal (2004-2008) to institutionalize and scale up RH (and in Kenya, additional HIV-prevention activities) within the routine duties of the participating ministries. FRONTIERS (and in Kenya, its partner, PATH) provided the following technical support in both countries:

- Identification and adaptation of the practices, tools, and materials that proved successful in the pilot projects
- Building the capacity of ministries and partners to plan, budget, and implement ARH and HIV-prevention activities
- Incorporation of ARH and HIV-prevention activities in routine ministerial procedures
- Support of the phased expansion or scale-up of these activities

The expansion projects followed different models. The Kenya project was a large scale-up effort that focused on the institutionalization, replication, and rollout of KARHP activities within the three participating ministries at the district, provincial, and national levels. In Senegal, the focus was on institutionalizing ARH activities within a range of governmental and NGOs and on exporting the multi-cultural model to several other African countries.

The Kenya expansion followed several overlapping phases: a 20-month revision and adaptation of materials after the pilot phase, a 12-month institutionalization and expansion in eight districts in Western Kenya, and a 26-month replication in four provinces (Nyanza, Eastern, Nairobi, and Central).

**Replication in Eastern and Nyanza Provinces:** In May 2006, replication of the KARHP began in two pilot districts in both Eastern Province (with technical support from FRONTIERS) and Nyanza Province (with support from PATH). Introduction of the ARH activities in two districts in each province proved sufficient experience to build a critical mass of trained ministry personnel, who could then introduce KARHP throughout all districts. In April 2007, the MOEST allocated Ksh2.1 million (U.S. $32,308) for the rollout of the KARHP curriculum in 502 schools in six districts in Nyanza and Eastern Provinces. Beginning in June 2007, PATH continued scaling up the KARHP intervention to all other districts in the two provinces, with funding from the USAID/PEPFAR bilateral APHIA II projects.

**Replication in Central and Nairobi Provinces:** In June 2007, FRONTIERS received support from PEPFAR/Kenya and USAID/Kenya to facilitate replication of the KARHP model by APHIA II partners in Nairobi and Central Provinces. Again, the replication followed the strategy of introducing KARHP into two pilot districts in each province, incorporating proven strategies such as cascade training for master trainers (at MOEST, MGSCSS, MOYA, and MOH), creating district- and provincial-
level intersectoral coordination bodies, and developing Management Information Systems (MIS).

Additional replications: In April 2008, FRONTIERS provided technical support to help the MOYA roll out the KARHP approach and the Tuko Pamoja life-skills curriculum to 70 youth polytechnic schools. The MOE allocated Ksh.1.5 million (U.S. $23,077) to expand the programme to schools in all 10 districts in Coast Province and has approved the teaching of life-skill education as a stand-alone subject in schools.

Key success actors:
The following factors were key to the programme’s success:

- The involvement of the line ministries through the formation of an inter-ministerial coordinating group
- Institutionalization of training through a cascade approach
- Institutionalization of ARH in the line ministries’ work plans
- Regular and coordinated support supervision, including M&E
- Sharing resources and costs at all levels
- Sensitization, mobilization, and advocacy

Lessons learned
Several lessons were learned in the course of implementing the programme and were noted, such as

- The multi-sectoral collaboration (partnerships in implementation and leveraging of resources) proved efficient and effective in transferring skills. It also improved acceptance and ownership of the process.
- Community involvement and the use of local resources are essential in enhancing ownership, support, and adaptation of the KARHP model.
- Evidence-based programming is effective when partners believe and own the evidence and continually apply it in planning, budgeting, implementing, and defining their level of involvement.
- Building national and local support teams strengthens the implementation and coordination of ARH activities and has a wider impact in the public-sector agencies.
- Public-sector agencies provide the best sustainable avenues to reaching the majority of youth in Kenya.

Challenges
The main challenges encountered were:

- Obtaining adequate technical assistance for partner ministries to implement the project (including planning, capacity building, integrating ARH within routine work plans, and monitoring project activities)
• Resource availability and complex budgeting and planning systems within the public sector
• Communicating findings effectively and convincingly among the varied partners, considering the nature of the audience
• Countering entrenched cultural beliefs in communities
• Transitioning responsibilities and pilot-project mentality to a ministry-owned programme mentality, and from donor to ministry support
• Estimating costs, especially in the pilot phase, because of a lack of proper data management and delays in the submission of reports

Recommendations

The following recommendations are in response to the lessons that were learned and the challenges that must be met:

• Lobby the government to put more resources into RH and ASRH.
• Expand the programme to cover the whole country.
• Continue health education at the Primary Health Care (PHC) level to ensure that people take charge of their health and mitigate against entrenched, unhealthy cultural practices.
• Implement various RH and population policies.
• Include data generation, management, and timely reporting and documentation in the programme.
• Institutionalize continuous consultation and briefing among the various line ministries to ensure continuity of the programme.

Reference

5. Friends of Youth

Background and rationale

Friends of Youth (FOY) originally comprised the Nyeri Youth Project (NYP), a collaborative project between the Population Council and Family Health Options Kenya (FHOK), and the Nyeri community in Central Province in Kenya. Based on formative research among youth and adults in Nyeri, the Nyeri Youth Health Programme (NYHP) employed parents who were nominated by the community to give youth between the ages of 10 and 24 SRH information and to promote an improved environment that would be responsive to their RH information and service needs. The project was locally designed and consistent with Kikuyu culture, in which parents traditionally ask trusted adults to provide SRH information to their children as they undergo puberty rites.

The formative research revealed that (1) young people often visit private providers when they require RH services, (2) young people prefer SRH information from trusted adults, and (3) peers do not provide reliable information, nor do they keep discussions confidential.

NYHP was a pilot intervention that lasted from 1997 to 2001 and was evaluated using a quasi-experimental research design, in which baseline and endline surveys were conducted in both experimental and control sites. NYHP made a significant impact on a number of behavioural indicators, including condom use, secondary virginity, and reduction in the number of sex partners. The project also improved the environment for young people in terms of communication regarding RH issues. Both males and females in the project site were more likely than young people in the control site to discuss SRH issues with a non-parent adult.

With the support of the CDC, which began in 2004, the NYHP has been scaled up to urban areas in Central Province (Nyahururu and Thika) and in the slums of Nairobi. Because of this expansion beyond Nyeri, the project came to be known as the Friends of Youth. This scale-up phase saw the introduction of subsidized HIV VCT services for young people in addition to the regular, subsidized RH services.

Contextual factors

Formative research in the pilot area in Nyeri, Kenya, found out that young people preferred to receive reproductive health (RH) and sexuality information from trusted adults rather than their peer educators, citing concerns that their age-mates do not provide reliable information or keep discussions confidential. Parents also preferred such information coming from trusted adults (aunts or uncles), a pattern consistent with the traditional way of passing sexuality education in reproductive health among the Kikuyu communities. Most young people indicated that they preferred private clinics when they needed reproductive health services, describing increased privacy and confidentiality from such facilities.
The FOY project was initially piloted in Nyeri municipality. A baseline survey was conducted in 1997 in both the intervention site and the control site (Nyahururu municipality), which was based on comparable ethnic and socio-economic composition. After three years of implementation, an endline survey measured changes associated with the project. Behavioral changes were detected associated with the FOY programme, though impact varied by gender. Among boys in the experimental area, positive changes were detected related to condom use and discussion of reproductive health issues. Among girls in the project site, positive behaviour change related to secondary abstinence, partner reduction, and communication on reproductive health. Most young people indicated that they preferred private clinics when they needed reproductive health services, describing increased privacy and confidentiality from such facilities.

When the FOY model was originally designed, the HIV epidemic in Kenya was beginning to escalate, but unwanted pregnancy and sexually transmitted infections (STI) remained the main reproductive health concerns of youth. By the time the model was being evaluated, it was becoming increasingly clear that young people — especially young women — were highly affected by HIV. As a result, the model was adapted to increase the information and support to youth on HIV-related issues.

**Objectives**

The overall goal of the project was to promote positive HIV behaviour among youth and provide youth-friendly HIV testing and support services in the five urban areas. Specific objectives included the following:

- Increase the number of young people receiving HIV behaviour-change education and services.
- Increase the number of people who are trained to provide HIV behaviour-change education and services for youth.
- Involve community and religious leaders and parents in HIV prevention and care activities for youth.
- Increase the number of young people receiving VCT services.
- Increase condom-distribution services.
- Increase the number of young people receiving information and services on gender-based violence (GBV).

**Interventions**

**Capacity building: Training a cadre of trusted adults.** The project advisory committee (PACs) and local communities, including parents and youth, screened and nominated trusted and respected adults to receive training to become FOY. Criteria for nomination included good standing in the community, good communication skills, ability and willingness to provide adolescents with reproductive health education, leadership qualities, nonjudgmental attitudes, and friendliness to youth.
**Outreach and education.** The trained FOYs were assigned to a number of households, in which they gathered demographic information on the adolescent members, such as age, marital status, and relationship to the household head. The FOY engaged all young people within the ages of 10 and 24, in their assigned areas, conducting visits at their homes or in such venues as schools or churches. They also formed dedicated, age-specific groups for young people whom they would not otherwise reach.

The FOY reached out to parents of adolescents, emphasizing the importance of open discussions and building their skills on how to talk to their children.

**Youth friendly and subsidized RH/HIV services (VCT and post-test counseling services).** Health facilities were identified within the project sites that were listed to participate in the project, based on providers’ interest in supporting young people. Providers from participating facilities (mostly from the private sector) were trained in providing youth-friendly services. FOY referred young people to these facilities using a coupon provided by the Population Council, which subsidized the cost of service. The cost of services was jointly subsidized, with the youth paying a nominal fee of US$0.75.

**Monitoring & Evaluation.** FOY kept records of all the contacts and referrals, which helped them to track their performances and patterns in service provision.

**Creation of a safe and supportive environment.** Stakeholders held meetings to sensitize and mobilize the community, which created acceptance, ownership, and support. In addition, members of the Project Advisory Committee (PAC) were drawn from local teachers, local administrators, selected service providers, religious leaders, and FOY representatives. The PAC was responsible for enhancing community ownership and recruitment of FOY.

**Results**

The results of the intervention were:

- Greater community participation and ownership
- Supportive environment for communication and community discourse on sensitive topics of youth sexuality and RH
- Improved knowledge regarding STI
- Improved communication and open discussion between parents and their children on sensitive issues of sexuality and RH
- Demand creation for information on post-test services and linkages to RH services
- Improved health-seeking behaviour among the youth, such as for VCT services
- Successful integration of HIV and RH services for youth
- Promotion of community ownership of the project by working through existing community structures, e.g., churches
• Conformity with the local cultural practices (getting information and guidance on sexuality from trusted adults)
• Demonstrable success of a program adapted to the changing needs of young people in Kenya
• Establishment of a youth-adult mentorship model
• Coupons subsidizing services for adolescent VCT clients are effective. In fact, the use of coupons has been expanded to cover nutritional supplements and CD4 count tests.

Lessons learned/success factors
The following lessons were learned during this intervention:
• Working with the existing social and community structures is key to success in ASRH and youth SRH behaviour.
• The communities know themselves and can be actively involved in shaping their own RH and sexual behaviour.
• Integrating RH services for adolescents is possible.
• Integrating nonprofessional people in the management of SRH for youth is possible as long as the right structures are used.
• Innovative approaches to financing RH care for the youth are possible.
• Partnership between the private and public sectors is possible for successful integration of HIV and RH services for the youth.
• Training appropriate to the trainees can ensure success of youth programmes.
• Creating demand for post-test services and linkages to RH services is possible.

Challenges
Successful interventions must overcome a number of barriers:
• The cost of RH services in private facilities has substantially increased, making the subsidy of the services an ongoing challenge for FHOK.
• Private providers are not in the habit of keeping records of their services, and therefore they under-report RH services.
• Currently, one-stop shops for HIV/RH services are limited. VCT is offered in a different facility than post-test services.
• FOYs report that although young people appreciate the HIV counseling that they receive, many do not proceed to be tested.
• Reaching parents and other adults continues to pose a challenge to FOYs, particularly in relation to the large number of adolescents who were reached.
**Recommendations**

Recommendations for proceeding with this best practice include the following:

- Establish effective referral mechanisms, which are important to break down an array of barriers to RH services for young people, such as psychological barriers, distance and cost barriers, and confidentiality.

- Scale up the FOY project countrywide, because it has helped prevent young people from experiencing the negative consequences of sexual activity.

**References:**


6. Reproductive Health Output-based Aid

Background

In October 2005, KfW Banking Group and the Government of Kenya initiated a pilot Output-Based Aid (OBA) programme. This pilot was considered Phase I of the project and ended in October 2008. Phase I project sites included two Nairobi slums, Viwandani and Korogocho, and three districts, Kiambu (Central Province), Kitui (Eastern Province), and Kisumu (Nyanza Province). Kiambu has both rural and urban residents. Kitui and Kisumu are both rural. Phase II will begin in 2009 and, if funding permits, the project will scale up to each of Kenya’s eight provinces.

The OBA programme is designed to give the patient the economic power to demand high-quality health care and to target high-risk or low-income patients for critical services. The OBA voucher programme in Phase I targeted primarily women living in poverty and offered three types of vouchers: an SM voucher for ANC and safe-delivery services, an FP voucher that provides one long-acting or permanent (LAPM) method, and a GBV voucher for counseling and treatment for individuals affected by domestic violence.

Although contraceptive use in Kenya has steadily increased over the past 30 years, results from the 2003 KDHS showed that FP use had reached a plateau. At the same time as contraceptive use has slowed, the Total Fertility Rate (TFR) has been on the rise. However, 58 percent of married people who are not using FP say that they intend to use it in the future, suggesting a significant, untapped latent demand.

Although the government of Kenya has supported FP, many challenges have continued to affect the FP programme. One main challenge has been the decrease in funding for FP as more resources have been designated to the prevention and treatment of HIV/AIDS. According to the 2003 KDHS, seven percent of all Kenyans and nine percent of women between the ages of 15 and 49 were HIV-positive (KDHS, 2003). Resources for HIV and AIDS have been essential over the past five years. However, because the approaches to this funding were not integrated with FP-related services, many health facilities were not able to increase their RH and FP capacity while they scaled up their HIV and AIDS programmes (Family Health International, 2005).

Uptake of FP, in particular, has declined over the last several years. According to the 2003 KDHS, injectables and oral contraceptives are the most popular methods. While use of all other methods has declined slightly, use of injectables has been on the rise. LAPMs have not been as popular as short-term methods for three main reasons: clients’ beliefs and lack of accurate knowledge, provider bias, and male bias and influence.

Rationale

It has been shown over the years that despite the input approach to providing health care, the poor do not access quality RH services. From various demographic health
surveys, the RH health burden still lies with the poor. In its efforts to meet the MDGs and the goals of Vision 2030, the government of Kenya has set out to test alternative ways of financing RH services for the poor and disadvantaged.

**Contextual factors**

The government and its development partners have typically used an input-based approach to development (i.e., supply-side financing) to address health issues in Kenya. This approach has over the years seen enormous financial resources channeled to the health sector for infrastructure, personnel, drugs, and supplies in a bid to improve the health of citizens.

Although the availability of these resources is necessary for service provision in the health sector, it is evident that some segments of the public, especially the poor, face significant barriers to using health services. These barriers include poverty, which is now estimated at 46 percent, and cost sharing, which was introduced in the health sector in the 1990s as part of the Structural Adjustment Programmes (SAPs).

The government and development partners have undertaken various measures to try to ameliorate the plight of the poor and to improve their access to essential health services. These measures, which include reducing or eliminating user fees and introducing a waiver policy for the poor, have not been consistent over the years in Kenya. Despite these efforts, the welfare indicators in Kenya have continued to worsen since the early 1990s.

**Objectives**

The objectives of the RH OBA project were as follows:

- Improve access and use of SM, FP, and GBV Recovery (GBVR) services for the economically disadvantaged in the five project sites.
- Improve (1) responsiveness and quality of services that are rendered through the accreditation process, (2) competition among service providers (except for gender violence), and (3) M&E processes.

The target population’s freedom of choice and purchasing power has been strengthened (human rights approach). Competition among the voucher service providers is driven by the clients’ choice and purchasing power. This is one of the built-in features of the OBA voucher-approach — i.e., providers who align their services with the clients’ needs and preferences should be more successful.

**Interventions**

The RH OBA project was implemented by a consortium of organizations, government agencies within different ministries, and donor agencies. During the preliminary planning stages of the project, the following activities were carried out by the various stakeholders so that they fully understood and appreciated their role in the project:

- Advocacy and sensitization
- Consensus building
• Capacity building
• Demand creation
• Documentation
• M&E

**Key stakeholders in the OBA voucher programme**

The main stakeholders and roles held during Phase I of the project were as follows:

• **KfW**: This donor organization funded Phase I of the OBA voucher programme, along with the government of Kenya.

• **National Coordinating Agency for Population and Development (NCAPD)**: NCAPD provided oversight for the voucher programme as a whole, including oversight of the Voucher Management Agency (VMA) and funding.

• **OBA Steering Committee**: This committee is made up of KfW, NCAPD, and both Ministry of Health (MOH) departments. It reviews and approves all project budgets.

• **Advisory Board**: Members include representatives from governmental agencies, nongovernment organizations (NGOs), and private organizations.

• **Price Waterhouse Coopers (PWC)**: A multi-national firm with auditing expertise, PWC is the VMA responsible for managing all operations of the programme. PWC contracts with voucher-service providers, manages voucher claims and provider reimbursements, conducts M&E, and oversees accreditation and quality assurance, marketing, and distribution of vouchers. The Population Council supports PWC in the technical aspects of monitoring the programme.

• **National Hospital Insurance Fund (NHIF)**: A Kenyan state corporation that provides medical insurance to Kenyans. For the OBA voucher programme Phase I, NHIF was responsible for accreditation and ongoing quality assurance of the voucher service providers.

• **Voucher Distributors**: Individuals based in project communities that are contracted by PWC to screen potential clients for eligibility (defined by residence in project sites and meeting poverty criteria) and to sell vouchers to clients who are eligible.

• **Voucher Service Providers**: Accredited mix of public, private, NGO, and faith-based organization (FBO) providers who participate in the voucher programme.

• **Actual and potential voucher clients**: Women and men who live in the project sites, satisfy poverty criteria, and are in the reproductive-age group. Most clients are women, but men can obtain FP vouchers for vasectomies.

The implementation of the RH OBA Project was undertaken in all the five sites mentioned above. In each of the sites, the local leaders were sensitized on the project
first, after which the general public was informed. The emphasis at this stage was on the overall benefits of the project and how the eligible clients could access the services.

As part of the preparatory activities, VMA contracted NHIF to accredit the project health institutions that would offer the targeted services to the public. In total, 54 health facilities were accredited to offer one or more of the targeted services. In addition to this, the VMA recruited voucher distributors from the local communities to administer the poverty-grading tools that are used to identify eligible clients. The distributors are registered groups or trusted individuals within the targeted communities.

A diagrammatic summary of the management of the RH-OBA project

The main target audience was low-income women. During Phase I, voucher distributors first used a poverty tool to assess whether a potential client qualified for the programme, and then conducted a home visit to verify the information received.

Marie Stopes Kenya (MSK) was contracted to develop regionally appropriate, participatory poverty-grading tools, and to adapt them to the Kenya context (based on a similar tool developed by Marie Stopes International [MSI] in Uganda) for each of the programme sites.

To do this effectively, MSK conducted 10 focus group discussions and five social-mapping exercises and visited more than 50 households. Draft poverty-grading tools were tested in the field before they were finalized for both the rural and urban
contexts. The MSK team identified six universal indicators: housing, access to health services, water source, sanitation, daily income, and average number of meals per day. They also identified three levels of poverty: very poor, poor, and medium. Poverty grading was based on an overall scoring system, with specified cut-off points for each level of poverty (Marie Stopes Kenya, 2006).

After verification of her eligibility, a woman could purchase the voucher and redeem it at one of 54 participating programme facilities. SM vouchers cost 200 Ksh; FP vouchers, 100 Ksh; and the GBV voucher was free to all clients.

The facilities accepted and registered voucher clients, administered services covered under the voucher, and filled out claim forms to obtain reimbursements. During this phase of the project, 18 private facilities, 13 FBO facilities, three NGO facilities, and 20 public facilities participated in the programme within the five project sites. All facilities were reimbursed the same amount. For the FP voucher, facilities were reimbursed 2,000 Ksh for implants, 1,000 Ksh for an IUCD, and 3,000 Ksh for Bilateral Tubal Ligation (BTL).

The money received from reimbursements could be used by these facilities to make improvements, such as hiring new staff, buying equipment and supplies, training, and renovating the facility.

The VMA oversaw all aspects of voucher distribution and facility reimbursement, including fraud monitoring. The VMA also conducted exit interviews with clients and ensured that they were given quality services.

**Documentation**

The process of documenting all the activities of the project was put in place and was part of the facilitative support supervision. Data and information was available in the implementing facilities and with the partners for their various activities. The documentation enabled sharing of information on the programme and made it easy to monitor and evaluate the progress and success of the programme based on the initial baseline survey.

**Monitoring and evaluation and operations research**

Monitoring and evaluation was from the start considered vital to successfully implementing the initiative, gauging its success, and determining the outcomes of the project. Several evaluations of the project were carried out: internal reviews and a midterm and a final evaluation.
Results

The results of the interventions were encouraging.

Table 10: Summaries of the number of clients reached with the different services offered under the project auspices

<table>
<thead>
<tr>
<th>Sites</th>
<th>SMH</th>
<th>FP</th>
<th>GBVR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kisumu</td>
<td>20,863</td>
<td>3309</td>
<td>33</td>
</tr>
<tr>
<td>Nairobi</td>
<td>11,189</td>
<td>1399</td>
<td>241</td>
</tr>
<tr>
<td>Kitui</td>
<td>9,395</td>
<td>1392</td>
<td>71</td>
</tr>
<tr>
<td>Kiambu</td>
<td>16,230</td>
<td>5177</td>
<td>7</td>
</tr>
<tr>
<td>Totals</td>
<td>57,677</td>
<td>11277</td>
<td>352</td>
</tr>
</tbody>
</table>

The KfW OBA SM voucher exceeded programme targets, while the FP voucher was not as successful. The table below compares actual voucher sales to the projected targets for FP and SM vouchers during Phase I of the OBA project (Price Waterhouse Coopers 2008).

Table 11. Comparison between actual sales and targeted sales

<table>
<thead>
<tr>
<th>Project Site</th>
<th>FP-Voucher Target</th>
<th>Actual Sales of FP Vouchers</th>
<th>Percentage of Target Reached</th>
<th>SM-Voucher Target</th>
<th>Actual Sales of SM Vouchers</th>
<th>Percentage of Target Reached</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Nairobi</td>
<td>8000</td>
<td>4533</td>
<td>57%</td>
<td>3200</td>
<td>10135</td>
<td>317%</td>
</tr>
<tr>
<td>2 Kiambu</td>
<td>20000</td>
<td>13844</td>
<td>69%</td>
<td>18800</td>
<td>18771</td>
<td>100%</td>
</tr>
<tr>
<td>3 Kitui</td>
<td>15000</td>
<td>1292</td>
<td>9%</td>
<td>12000</td>
<td>13594</td>
<td>113%</td>
</tr>
<tr>
<td>4 Kisumu</td>
<td>20000</td>
<td>3167</td>
<td>16%</td>
<td>19000</td>
<td>21492</td>
<td>113%</td>
</tr>
</tbody>
</table>

SM services: About a year and a half into the implementation of the RH-OBA Project, an assessment was carried out using data from the health facilities accredited to the project. The objective was to determine the change in the number of SM clients attending these facilities as a result of the voucher scheme. Baseline information from these facilities was compared with the number of deliveries registered after the introduction of the project. The table below gives a summary of the findings for each site.
Table 12: The increase in SM clients over the baseline data

<table>
<thead>
<tr>
<th>Site</th>
<th>Percent Increase in SM Uptake</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kisumu</td>
<td>51.8%</td>
</tr>
<tr>
<td>Nairobi</td>
<td>-9.7%</td>
</tr>
<tr>
<td>Kitui</td>
<td>149.6%</td>
</tr>
<tr>
<td>Kiambu</td>
<td>38.8%</td>
</tr>
<tr>
<td>Overall</td>
<td>21.3%</td>
</tr>
</tbody>
</table>

**FP and GBVR services:** These have not done very well under the voucher scheme. After two years of implementation, about 6,600 voucher clients, out of a target of 62,000 clients, have accessed the FP services offered.

Table 13: Family planning-voucher clients, June 2006 to May 2008

<table>
<thead>
<tr>
<th>Services</th>
<th>Kisumu</th>
<th>Nairobi</th>
<th>Kitui</th>
<th>Kiambu</th>
</tr>
</thead>
<tbody>
<tr>
<td>BTL</td>
<td>833</td>
<td>97</td>
<td>476</td>
<td>891</td>
</tr>
<tr>
<td>Implants</td>
<td>801</td>
<td>873</td>
<td>286</td>
<td>1907</td>
</tr>
<tr>
<td>IUCD</td>
<td>79</td>
<td>98</td>
<td>11</td>
<td>216</td>
</tr>
</tbody>
</table>

From the table above, it is evident that most of the voucher clients preferred to use implants for FP, followed by BTL. IUCDs were the least preferred FP method among the voucher clients. Most of the clients who used the vouchers to access FP services were from the districts of Kiambu and Kisumu.

The low uptake of FP services under the project has been attributed to the range of methods being offered (long-term methods). Evaluations of the project in 2007 recommended including other methods in order to attract more clients and undertaking more awareness campaigns to dispel myths and misconceptions about long-term FP methods.

So far, the project has managed to offer GBVR services to about 315 clients. Over 70 percent of these clients were from the Nairobi and Kiambu sites. The two
evaluations of this project that were undertaken in June and December 2007, respectively, indicated that this kind of service might not be suitable for a voucher scheme. In addition, the various field-visit reports for the project have identified various socio-cultural and legal issues that need to be overcome before clients in need of GBVR services can freely seek medical attention. These issues include stigma, community perception, and mechanisms for handling GBVR cases.

**Sustainability**

The sustainability of the RH OBA project is envisioned in the context of the financing approaches within the health sector. This includes SWAP and the establishment of a government budget line-item for OBA. With regard to the latter, efforts are underway to secure funding from the government for further project implementation. This effort began with the inclusion of the OBA approach in the Vision 2030 first Medium Term Plan.

**Replicability**

In the East African region, the OBA programme has posted similar results with increases in use. This was noted in Uganda and the programme is ongoing.

In Kenya, the programme is being designed for expansion to the remaining eight provinces in this year. The lessons learned have been taken into account in the second phase.

**Lessons learned**

The project provided an opportunity to learn several things, which will be useful in making improvements in the replication, expansion, and roll out of the project in different or similar environments.

These lessons include the following:

- Demand for RH services in the sites has increased as a result of the OBA voucher scheme.
- Quality of health care in the facilities accredited to the project has improved as a result of the reimbursements made by the project.
- The voucher scheme works better in the urban areas compared with the rural areas, mainly because of the difference in infrastructure availability.
- Programme commitment to intervention by the Kenya Ministry of health and all the partners is critical for sustainability.
- Policies and guidelines should be reviewed to ensure appropriate financing modes that can ensure equity and access to RH and allied services.
- Partnering with local stakeholders at all levels of implementation is critical.
- Community initiative and partnership is key to service and commodity uptake.
- Collaboration and leveraging of resources should be encouraged in the expansion.
Challenges

The main challenges were discovered to be the following:

• Preventing fraud by both the voucher distributors and the service providers
• Verifying the eligibility of clients requesting vouchers
• Improving the uptake of FP and GBVR services
• Working with weak health infrastructures, especially for ensuring accessibility and equity for health-care financing
• Inadequate support from providers in the private sector for certain services that were not rewarding in terms of reimbursements
• Creating demand (which includes reassuring clients that the services will always be available)

Recommendations

Some of the recommendations made from Phase I of the project are summarized below:

• Move the RH OBA Project to the ministries responsible for the health sector to facilitate scale-up.
• Increase the range of FP methods that are offered under the project.
• Attempt to quantify the contribution of the project in terms of reversing the negative population indicators registered in the country.
• Strengthen the gains made while finding ways to overcome the challenges. In this regard, identify the poor and provide quality services to them.
• Accredit more service providers.
• Give priority to increasing awareness of and education in RH issues.
• Document the lessons learned so far and share them with stakeholders, to encourage them to buy into the project concept.
• Use the lessons to inform the proposed National Social Health Insurance Scheme.
• Mobilize additional resources from the government and development partners in order to increase the geographical coverage and add the number of services that are offered. Give more consideration to the sustainability of the project during the pilot phase.
• Partners and stakeholders who support the MOH of Kenya should work within the existing structures of the ministry for the success of a programme.
• Encourage advocacy, sensitization, and consensus building.
• Obtain regular, supportive supervision.
• Advocate for the inclusion of the project in the AOP of MOH of Kenya and other line ministries to ensure the continuity and sustainability of the project.
• Advocate for a budget line to be included for all the components to ensure that services will be continuous.

References


7. Taking Critical Maternal and Newborn Care Services to the Homes through Community Midwifery: the Kenya Model

Background

Kenya has seen an improvement and subsequent decline in reproductive health and maternal and child health indicators over the past several decades. This is contrary to the global evidence that indicates maternal and prenatal mortality rates decline when women have access to a continuum of skilled care during pregnancy, birth, and the postpartum period. In Kenya 88 percent of the women attend an ANC clinic at least once; more than 58 percent deliver outside the designated health facilities with skilled attendants. It is estimated that only 10 percent of those delivering at home receive any type of postnatal care. The maternal mortality rate is 414 per 100,000 live births. The neonatal mortality rate is 33 per 1,000 live births, with the majority of deaths occurring within the first week of life. The CPR (for all methods among married women) rose from 10 percent in 1984 to 39 percent in 1998. It reached a plateau between 1988 and 2003, indicating a significant unmet need for FP. In Kenya, where there have been positive moves to equip health facilities to provide maternal neonatal health (MNH) services, there has been a downward trend in the number of women using the facilities for delivery.

Given all the information and data available on health care delivery in Kenya, the MOH’s second National Health Sector Strategic Plan 2005-2010 (NHSSP) shifts the emphasis from the burden of disease to the promotion of individual and community health. To implement this plan, the KEPH adopts a broad approach that focuses on the stages of human development.

Rationale

Limited facility delivery by a skilled attendant (42 percent for Kenya), inadequate postnatal care and follow up, and unmet need for FP among women following delivery is not unique in Kenya. These problems are widely acknowledged in sub-Saharan Africa.

It has been shown over the years that maternal and neonatal mortality and morbidity can be reduced by having a continuum of care in pregnancy by a skilled birth attendant, whether at the health facility or at the home level.

Contextual factors

Despite the improvement in Kenya’s health facilities and their perceived ability to provide skilled care at birth, more than 58 percent of mothers still deliver without a skilled attendant. Although over 88 percent of women in Kenya attend an ANC clinic at least once during pregnancy, a skilled attendant assists at only 42 percent of births. There are regional disparities within Kenya on who provides support during childbirth. In Central Province, over 70 percent of women deliver with a skilled attendant, compared to 28 percent in Western Province.
Results from one district in Western Province, where midwives were given the necessary equipment and support to assist women during birth at home, showed an increase from one to nine percent in home births attended by skilled health workers between 2001 and 2003. A concurrent decrease in the use of traditional birth attendants (TBAs) was seen. This indicates that skilled attendance in the community is possible and is a good alternative for women who are unable to reach a health facility.

The area where this intervention was carried out demonstrates some of the socio-cultural issues that surround pregnancy and childbirth in an African setting.

**Objectives**

The overall goal of the intervention was to improve the quality of normal pregnancy, delivery, and postnatal care for women within the community, thereby reducing maternal and perinatal morbidity and mortality.

The specific objectives of the intervention were as follows:

- Improve access to skilled care within the socio-cultural and economic context. Identify a package of effective services (including postpartum FP) that self-employed midwives can provide with minimal supervision from the MOH of Kenya.
- Identify mechanisms for linking self-employed midwives with existing MOH district-level health systems.
- Increase RH knowledge among women and male partners and the community at large.
- Assist women to make birth-preparedness plans.
- Provide a continuum of care from antenatal, labor, childbirth, and postpartum care (PPC), including FP.
- Involve males and the entire community in the MNH and RH service delivery.

**Interventions**

The interventions of the programme were carried out through the following key activities:

- Rapid assessment of the maternal and newborn health care services
- Stakeholders meetings to share the findings of the assessment, and determine their implications for MNH and RH planning and programming
- Identification and selection of retired midwives in the community
- Training and supervision
- Follow-up
For successful implementation of the interventions, the programme was divided into three phases:

Phase I, preliminary activities:
- Rapid assessment of the RH situation in the chosen pilot district
- Building a consensus with the community, the health administrators, and service providers in the district
- Identification and selection of the community midwives

Phase II, introduction of the interventions:
- Training community midwives, clinical attachment, business-skills development, procurement and distribution of supplies and equipment
- Follow-up and supervision

**Rapid assessment:** A rapid assessment of maternal and newborn health and services available in the community catchment area was made. Some of the issues looked at were the place of delivery, persons conducting the deliveries, causes for non-optimum use of health facilities for delivery, the availability of professional midwives in the community, and the probable costs and challenges of maintaining and sustaining the midwives in the community.

**Advocacy and sensitization:** The rapid assessment and the results of the SM-demonstration project in one district in Western Province showed that women are willing to be attended by skilled birth attendants so long as the providers are accessible, affordable, and either known to them or recommended by a trusted individual.

A team of health professionals went on a study tour in Ghana to learn and share experiences on the potential of community-based midwifery. The experience proved useful in central, regional, and district level advocacy, sensitization, and mobilization. Four districts were randomly selected based on pre-agreed criteria.

All this information was shared with the various players and stakeholders in RH care delivery. The DRH, Provincial Health Management Team (PHMT), District Health Management Team (DHMT), District Health Management Board (DHMB), development partners, and the various administrators of the facilities in the programme districts met and reached a consensus with the various levels of the MOH of Kenya. This consensus would be part of the implementation and supervision of the programme. It was achieved through several consultation meetings with the following: DRH, PHMT, DHMT, DHMB, development partners and the various administrators of the facilities in the programme districts.

**Implementing Partners:** The project was implemented by MOH of Kenya with assistance from the following:
• The Population Council and FRONTIERS provided technical support.
• The professional bodies Kenya Obstetrical and Gynecological Society (KOGS), the National Nurses Association of Kenya (NNAK), the Nursing Council, the Medical Practitioners and Dentists Board (MPDB), and the National Clinical Officers Council ensured the providers were eligible to practice and maintained good conduct of practice.
• The University of Nairobi’s Department of Obstetrics and Gynecology ensured that all the practices and content of the training met acceptable standards of care.
• DFID provided the funds for the safe motherhood demonstration project.
• USAID supported the scale-up project in the four districts.

Capacity building and service delivery

This process began with identification and selection of professional midwives to work in the areas in which they were identified. They needed to satisfy the following criteria:
• Be a registered or enrolled Community Midwife (CM) or a registered clinical officer with RH training
• Have evidence of retention in a professional register
• Be retired or otherwise out of formal employment
• Have obstetric or midwife skills
• Be a permanent resident within the community to be served, or be prepared to live within that community

Having satisfied the above criteria, the CMs went through a capacity-building and orientation exercise. During the orientation sessions, the CMs were taken through the technical skills in FANC, basic obstetric care, and management of maternal and neonatal complications. The orientation and training package included practical sessions that involved the following:
• The basic delivery skills
• Linkages, support, and networking
• Cost and payment for services
• Business-skills training
• The basics of transport and referral
• Documentation for M&E

A CM task force was created, made up of members of the SM task force. The task force was responsible for developing training materials, guidelines, and orientation packages, which would spell out the mandate of the CMs.
DRH, with support from FRONTIERS, developed record-keeping tools to help track the activities of the CMs at the district level. The CMs used the tools to record the services that they provided.

**Documentation**

The process of documenting all the activities of the project was put in place and became part of the facilitative support supervision. Data and information was available with the CMs and they reported to the DPHN. Documentation enabled participants to share information and made it easy to monitor and evaluate the progress and success of the programme based on the initial baseline survey.

**Monitoring and evaluation**

M&E was from the start considered vital to successfully implementing the initiative and gauging its success. During the planning of M&E, measures were put in place to ensure appropriate documentation of all activities throughout the life of the project. There was a baseline survey and an end-of-intervention survey, which used various quantitative and qualitative methods. The results were all encouraging. The qualitative reports showed particularly encouraging remarks about how the CMs are perceived in the community. The tables below show some of the sampled results of the evaluation.

**Table 14. Skilled attendant during delivery in 2007**

<table>
<thead>
<tr>
<th>District</th>
<th>Expected live births</th>
<th>Deliveries by skilled attendant</th>
<th>Deliveries at facility</th>
<th>Deliveries by CMs</th>
<th>Percent of deliveries by CMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lugari</td>
<td>12,696</td>
<td>2047</td>
<td>1829</td>
<td>218</td>
<td>10.6%</td>
</tr>
<tr>
<td>Mt Elgon</td>
<td>9340</td>
<td>970</td>
<td>749</td>
<td>221</td>
<td>22.8%</td>
</tr>
<tr>
<td>Bungoma</td>
<td>58,110</td>
<td>7453</td>
<td>7199</td>
<td>254</td>
<td>3.4%</td>
</tr>
<tr>
<td>Butere/Mumias</td>
<td>28,920</td>
<td>3880</td>
<td>3684</td>
<td>196</td>
<td>5.1%</td>
</tr>
<tr>
<td>Total</td>
<td>109,066</td>
<td>14350</td>
<td>13461</td>
<td>889</td>
<td>6.1%</td>
</tr>
</tbody>
</table>
Table 15. Number of women referred by CMs

<table>
<thead>
<tr>
<th>Reason for referral</th>
<th>Number referred</th>
<th>Total referrals (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstructed labor</td>
<td>12</td>
<td>20%</td>
</tr>
<tr>
<td>Malaria in pregnancy</td>
<td>10</td>
<td>16%</td>
</tr>
<tr>
<td>Anemia in pregnancy</td>
<td>8</td>
<td>13%</td>
</tr>
<tr>
<td>Postpartum hemorrhage</td>
<td>7</td>
<td>12%</td>
</tr>
<tr>
<td>Retained placenta</td>
<td>3</td>
<td>5%</td>
</tr>
<tr>
<td>Fetal distress</td>
<td>4</td>
<td>7%</td>
</tr>
<tr>
<td>Previous surgical birth</td>
<td>4</td>
<td>7%</td>
</tr>
<tr>
<td>Sepsis</td>
<td>4</td>
<td>7%</td>
</tr>
<tr>
<td>Severe PET</td>
<td>3</td>
<td>5%</td>
</tr>
<tr>
<td>Multiple pregnancies</td>
<td>3</td>
<td>5%</td>
</tr>
<tr>
<td>Ruptured uterus</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Baby with Spina Bifida</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Prematurity</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>61</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Table 16: Proportion of FP delivered by CMs in 2007

<table>
<thead>
<tr>
<th>District</th>
<th>Injectables (%)</th>
<th>Pills (%)</th>
<th>Condoms (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lugari</td>
<td>11</td>
<td>19</td>
<td>1</td>
</tr>
<tr>
<td>Mt Elgon</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Bungoma</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Butere-Mumias</td>
<td>1</td>
<td>6</td>
<td>20</td>
</tr>
</tbody>
</table>
Results

The project findings indicated that CMs were respected and accepted in the community and were able to provide the following services:

- A continuum of care to pregnant mothers and newborns, including safe-delivery services, PPC, and FP at the community level
- Documentation of their activities
- Appropriate references

When interviewed, the beneficiaries of the CMs’ services said that proximity, accessibility, cost, confidence, and being part of the community encouraged them to use the CMs during delivery.

Replicability

This project was a follow-up of the SM demonstration project, which was in one district. and was replicated in four districts in Western province.

Sustainability

The fact that the strategy has been mainstreamed in the MOH’s FP programme enhances its sustainability. Women and their families are demanding more services, which will enhance the sustainability of the initiative. The MOH needs to look seriously at the issues of health care financing, especially those in rural areas.

Lessons learned

The project provided an opportunity to gain valuable insights that will be useful in making improvements to any future replication, expansion, and rollout in different or similar environments.

Specific lessons learned include the following:

- Payment to the CMs for their services can be made in a variety of ways, such as exchanges (e.g., farm produce, labor, or rent-free land) or in installments.
- FP services are more rewarding to both the clients and the provider.
- Purchase wholesale the commodities that are not supplied.
- Most women still prefer to deliver at home even if they attend an ANC clinic at a health facility. Many reasons and theories have been advanced to explain this.
- Acceptability was high because the CMs are residents of the area.
- Building activities on evidence (especially synthesis and discussion of local evidence) is more acceptable.
- Programme commitment to intervention by the MOH and all the partners is critical for sustainability.
• It is necessary to review policies and guidelines to ensure appropriate content.
• Partnerships with local stakeholders at all levels of implementation is critical.
• Community initiative and partnership is key to the uptake of services and commodities.

Success factors
The following factors contributed to the success of the project:
• Leadership at various departmental levels of the MOH of Kenya
• Planning, consensus building, partnership, and teamwork
• Community involvement at various stages of the intervention
• Clear and achievable objectives
• Understanding of the socio-cultural aspects of MNH care in the communities where the intervention was taking place
• High profile of the intervention during its launch (by a local politician who was at the time an assistant minister in the MOH and an OB/GYN by training)

Challenges
During the course of the implementation of the programme, several challenges were encountered:
• Inadequate and erratic supplies and commodities
• Inadequate support from providers
• Linkages with the formal health system
• Obtaining payment, especially in the remote rural areas
• RH care financing at the community level where TBAs held sway
• Decisions and acceptability of various modes of health care financing, in cash or in kind
• Meeting the demands of the CMs’ clients for more services like VCT, providing antiretroviral therapy (ART) for PMTCT
• Communication and transportation when referrals are needed
• Obtaining sources of the initial supplies, drugs, and equipment
• Community involvement, support, and linkages with Community Own Resource Persons (including TBAs)
• Service charges for the very poor
• Policy issues, such as licensing and certification
• Sustainability
**Recommendations**

Policy formulation strengthens programme commitment and sets an enabling environment for programmes by giving them credibility and visibility. For the Community Midwifery Model to gain momentum, the following issues need to be resolved in RH policy:

- The Nursing Council and the MOH need to consider and agree on a specific *Certificate to Work* for CMs, which will be issued by the MOH.
- The MOH of Kenya needs to clarify that skilled attendance at home is allowed.
- A clear policy directive of how the CM will link with the formal health system is needed.
- The role of the community and the health sector in setting up and maintaining referral mechanisms (emergency transportation funds, etc.) needs to be decided.
- The community must be involved in order to ensure the model is sustainable through prepayment schemes and flexible modes of payment for home birth services.
- Linkages and networking with other community-based care programmes are required to promote information exchange, build alliances, and help create complementary and reinforcing programmes: for example, PMTCT, Integrated Management of Childhood Illnesses (IMCI), and HBC.

Other recommendations are:

- Support skill development for maintaining quality of care.
- Partners and stakeholders who support the MOH should work within the existing structures of the MOH for the success of the programme.
- Help CMs to achieve financial stability by looking at the various options of health care financing, paying them for the services they render in the community, even to the poor.
- Expand the mandate of CMs to respond to other RH-related services.
- Strengthen and support the linkages between the CMs and the formal health care system through the DHMT.
- Have regular consultations among stakeholders on a project.
- Encourage advocacy, sensitization, and consensus building.
- Maintain regular supportive supervision.
- Advocate for inclusion of the project into the AOP of the MOH in order to continue and sustain the project.
- Advocate for a budget line to be included for all project components to ensure that the services will be continuous.
References


8. Integrating Voluntary Counseling and Testing into Family Planning Centers in Kenya

Background

In Kenya, as in most countries, FP services and HIV VCT services have traditionally been offered separately. Integrating counseling and testing (CT) for HIV into FP increases the range of services available for FP clients, many of whom could be at risk of acquiring STI, including HIV, in high-prevalence settings. Systematic evidence about offering CT services in FP settings has remained extremely limited, despite the widespread interest in FP-HIV integration. Health-policy makers, however, have begun to recognize the missed opportunities and lost efficiency in this parallel approach.

The current policy environment favors integration of services as presented in the following documents: The National RH Strategy (1997-2010) and the National Health Sector Strategic Plan (NHSSPII) 2005-2010.

Following other interventions, it has been shown that integrating FP into VCT services is feasible, and yet the reverse has not been carried out. Elsewhere in the Sub-Saharan region, various models of integration of VCT into FP have been tried and found to be feasible.

Two models were then developed and tested in response to the various concerns by the MOH of Kenya within the context of the current policy environment. Family planning plays an important role in HIV/AIDS prevention, and VCT can reach sexually active clients who do not typically seek FP services, such as men and adolescents, as well as HIV-positive women who wish to prevent unwanted pregnancies.

After studies showed that the integration of services in Kenya was feasible, the Kenyan Ministry of Health charged FHI and various partners with determining the best way to implement integration of FP into VCT across the country. A subcommittee was established under the leadership of the MOH. The other members of the subcommittee were implementing partners, including FHI. This subcommittee developed the strategy of integrating FP/HIV services.

Rationale

Emerging evidence from research findings in the region indicates that integrating VCT into FP services is acceptable and has the potential to improve quality of care. Towards achieving this goal, the MOH drafted a strategy on integrating VCT and FP services, stating: “A major concern of the Kenya Government, programme implementers, and donors is that the VCT programme is evolving as a parallel programme to other efforts, especially those of the MOH that are aimed at decentralizing and integrating services.” This statement is given due consideration in this programme.
Implementing and evaluating this practice will help the MOH make evidence-based programmes for integrating these two services.

**Contextual factors**

The call for integrating VCT into FP services is coming at a time when the government is grappling with an increasing population of sexually active people, a shortage of staff in its health facilities, and a paradigm shift in resource allocation to the various RH services. The parallel route of implementing the various RH services has not proven to be cost effective over the years, or beneficial to the consumers of the services. Experiences from other integration programmes, such as FP into VCT, STI into FP, and MCH/FP services, have accumulated evidence that shows clients are more comfortable with a one-stop provision of services.

**Objectives**

The objectives of this implementation are summarized below:

- Develop and implement a model of integration that educates FP clients about VCT and offers them CT for HIV within the routine visit by a provider.
- Develop and implement a model of integration that educates FP clients about VCT and refers clients interested in testing and post-test counseling to a specialized VCT service provider.
- Describe the feasibility of implementing each of the two models and provide perspectives on their implementation.
- Assess the implementation of the two models in the number of the health care delivery settings in terms of their acceptability to clients, effectiveness in increasing the uptake of VCT, and incremental costs.
- Assess the effect that integrating VCT has on the quality of FP services received.
- Disseminate and use results to create the conditions for a scale-up.

**Interventions**

The intervention of the VCT into FP integration programme was implemented through a series of activities:

- Advocacy, sensitization, and consensus building at the national, provincial, and district levels and among other stakeholders
- Formulation of an FP working group and VCT integration subcommittee
- Development of a conceptual framework upon which two models — the testing model and the referral model — were based
- Development of training materials
- Balanced Counseling Strategy (BCS) Plus (see explanation on page 77)
- Capacity building, which included training health providers and strengthening basic supplies, commodities, and routine data collection on FP and VCT services
Advocacy, sensitization and consensus building involved discussions at the national level with the FP-VCT working group and other partners. The working group was composed of VCT and FP experts from NASCOP (subcommittee co-chair), the DRH (co-chair), FHI (facilitator), JHPIEGO, AMKENI, the CDC, Kenyatta National Hospital, KICOSHEP, the Population Council, and the National Leprosy and Tuberculosis Programme. The working group was charged with the task of developing a national integration strategy that would ensure the programme’s success.

Advocacy and sensitization meetings were held with the regional and district level health managers, partners, and service providers in the areas where the programmes would be implemented to obtain their support. During the consensus building, the participants decided the types of services that could be provided at the various levels of health care service delivery, from Level I to Level VI of the MOH health-delivery structures.

Two levels of integrating HIV/AIDS CT into FP services were proposed:

- Level 1 involved risk assessment for HIV and STI, IEC on VCT, and referral for CT and other services.
- Level 2 involved all VCT services in Level 1 plus pre-and post-test counseling.

Both of these models were applied in the intervention in the Central Province sites (Nyeri and Thika).

The targets of the conceptual framework were grouped into four categories: (1) targeted results of services to the client, (2) services that the client would be offered at the integration clinic, (3) interventions, and (4) factors that would allow these goals to be achieved.

The targeted results of the services to the client would be as follows:

- Improved health
- Desired fertility intentions addressed
- Enhanced HIV and STI prevention efforts
- Promotion of safer sex and dual protection
- HIV status determined
- Increased uptake of CT services for HIV
- Improved quality of FP services

The following services would be offered to new and repeat clients at an integration clinic:

- Routine information and education for HIV and risk assessment (verbal screening) for RTI and STI
- Routine offer of HIV CT services in FP consultations
• FP clients to benefit from IEC and services for HIV in one visit, preferably by one provider
• Referrals for services not offered on site

The following interventions would be taken to achieve the above:

• Training of health providers
• Availability of FP commodities and rapid test kits for HIV and other supplies
• Use of BCS job aids
• Training manuals and protocols
• Supervision and monitoring
• Modification of registers

The following factors would enable these goals to be realized:

• Enabled health policies
• Functional management systems
• Functional procurement and logistics systems
• Changes in service delivery
• Availability of space and infrastructure

**Development of training material:** Independently, but informed by the lessons learned from the feasibility study, JHPIEGO and Engender Health/AMKENI had each started developing VCT training materials. JHPIEGO developed an orientation package about FP and VCT integration for nonclinical FP and VCT providers. AMKENI created an integration training manual geared toward clinical providers. These two manuals were merged to form the MOH’s *Family Planning for Voluntary Counseling and Testing Providers: An Integrated Approach to Counseling and Service Provision* trainers’ manual. This manual was used as a reference training material along with other materials:

• Family Planning for Service Providers
• National Guidelines on Reproductive Tract Infection Services
• The National PMTCT Training Manual

Three sets of training materials were developed: a trainer’s manual, a trainee’s manual, and a national protocol. The manuals covered information on the following issues:

• Benefits of integration
• Different levels of integration
• Assessing a client’s risk for unintended pregnancy
• Counseling issues related to HIV and contraception
Reproductive physiology

Contraceptive methods with an emphasis on condoms and dual method use

Helping clients make informed choices

The following organizations and institutions were involved in this exercise: DRH, NASCOP, PHMT (Central Province), DHMT (Nyeri & Thika), the Population Council, and FHOK, among others.

**Balanced Counseling Strategy Plus:** This is a counseling approach based on a toolkit that consists of several job aids to illustrate and facilitate structured FP consultations. Trainers in Kenya reviewed, modified, and adopted various versions of the approach.

**Capacity building**

Getting the sites and staff ready to integrate services consisted of (1) training providers and health administrators, and (2) building the capacity of the FP service-delivery points to be able to provide the added services of VCT (Levels I and II).

The feasibility assessment revealed that VCT providers’ clinical backgrounds varied widely and were associated with the type of facility in which they worked. Providers in larger health facilities had more clinical training. The training of service providers therefore addressed issues of integration, updates on FP, RTI, and HIV, reproductive rights, informed choice, consent, safe sex, dual protection, value clarification, risk assessment, and the use of BCS Plus, record keeping, logistics management, and referral.

A build-up of basic supplies, commodities, and routine data collection on FP and VCT services was emphasized. Calculation of commodity requirements was well covered. Data generation, compilation, interpretation, and use at source were also discussed during the trainings.

Supportive supervision was conceived to be part and parcel of capacity building and also informed M&E. Its basic objective was to (1) ensure that the trained providers were putting in practice what they had learned during the training, and (2) determine the providers’ perceptions and feelings about the programme.

**Monitoring and evaluation**

The evaluation of the programme was designed at the project’s conception. Because the project involved two models of intervention, various facilities were selected and distributed to the different models. Monitoring was done on a monthly basis and was based on service statistics from MOH registers and a review of information on vouchers. It was carried out by DHMTs. Evaluation of the programme was conducted by the Population Council, DRH, and NASCOP in collaboration with the PHMT and DHMTs. Key indicators that would show progress were added to the register in the intervention clinics before the activities were initiated.
Results

Quantitative and qualitative methods of evaluation were used at the beginning of the project and at the end to compare the findings and gauge the success of the programme. The results are summarized below:

- At the baseline, the majority of the facilities had the minimum basic equipment, supplies, infrastructure, and staff to carry out integration activities in both models.
- Integrating CT into FP proved feasible and acceptable.
- Quality of counseling on STI and HIV issues improved.
- Counseling on condoms and dual protection and their use improved.
- Counseling on HIV CT increased during FP consultations.
- Use of the BCS Plus approach significantly improved the quality of integrated services.
- The number of clients who were offered and obtained HIV CT increased.
- Incremental costs for integrating CT into FP services are affordable.

The three tables below illustrate these findings.

Table 17. Availability of basic equipment, supplies, infrastructure, and services for FP and HIV/AIDS

<table>
<thead>
<tr>
<th>Category</th>
<th>Testing Model N=9 (%)</th>
<th>Referral Model N=14 (%)</th>
<th>Pooled N=23 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of equipment</td>
<td>76</td>
<td>74</td>
<td>74</td>
</tr>
<tr>
<td>Availability of FP supplies</td>
<td>52</td>
<td>43</td>
<td>46</td>
</tr>
<tr>
<td>Availability of HIV and STI supplies</td>
<td>81</td>
<td>80</td>
<td>81</td>
</tr>
<tr>
<td>Availability of infrastructure</td>
<td>83</td>
<td>84</td>
<td>84</td>
</tr>
<tr>
<td>Provision of FP services</td>
<td>73</td>
<td>56</td>
<td>63</td>
</tr>
<tr>
<td>Provision of HIV and STI services</td>
<td>77</td>
<td>71</td>
<td>73</td>
</tr>
<tr>
<td>Overall mean score</td>
<td>74</td>
<td>68</td>
<td>70</td>
</tr>
</tbody>
</table>

Staff

<table>
<thead>
<tr>
<th>Category</th>
<th>Testing Model N=9 (%)</th>
<th>Referral Model N=14 (%)</th>
<th>Pooled N=23 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average number of enrolled nurses and nurse midwives in the MCH/FP unit</td>
<td>4</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Average number of registered nurses and nurse midwives in the MCH/FP unit</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
### Table 18. Proportions of consultations in which FP issues were discussed

<table>
<thead>
<tr>
<th>Type of Consultation with Provider</th>
<th>Testing Model Nyeri</th>
<th>Referral Model Thika</th>
<th>Pooled Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline (N=214)</td>
<td>End-line (N=210)</td>
<td>Baseline (N=324)</td>
</tr>
<tr>
<td>1. Discussion of reproductive intentions</td>
<td>13</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td>2. Discussion of previous use of FP</td>
<td>66</td>
<td>79</td>
<td>66</td>
</tr>
<tr>
<td>3. Discussion of two or more methods</td>
<td>43</td>
<td>53</td>
<td>45</td>
</tr>
<tr>
<td>4. Choosing preferred method</td>
<td>76</td>
<td>95</td>
<td>92</td>
</tr>
<tr>
<td>5. Discussion of how chosen method works</td>
<td>34</td>
<td>42</td>
<td>54</td>
</tr>
<tr>
<td>6. Explanation of advantages and disadvantages of chosen method</td>
<td>25</td>
<td>48</td>
<td>50</td>
</tr>
<tr>
<td>Total score (0-6)</td>
<td>2.52</td>
<td>3.23</td>
<td>3.16</td>
</tr>
</tbody>
</table>

Note: The summary score shows that the increase in quality was higher in the referral-model clinics, although these did start at a higher-quality level than testing-model clinics. The greater increase in this group could be attributed to the fact that providers in the referral-model clinics (Thika District) were much more likely (75 percent) to have been observed using the BCS-Plus approach during consultation than the testing-model clinics (41 percent) (Nyeri district). This result supported other findings from other studies that BCS-Plus does have an effect on the quality of FP counseling.
Table 19: Discussion of STI/HIV issues with FP clients

<table>
<thead>
<tr>
<th>Type of consultation with provider</th>
<th>Testing Model Nyeri</th>
<th>Referral Model Thika</th>
<th>Pooled Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline (N=214) %</td>
<td>End-line (N=210) %</td>
<td>Baseline (N=324) %</td>
</tr>
<tr>
<td>1. Discussion of client’s history of STI symptoms</td>
<td>18</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td>2. Discussion of number of sexual partners</td>
<td>5</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>3. Discussion of STIs, HIV, and AIDS</td>
<td>48</td>
<td>84</td>
<td>30</td>
</tr>
<tr>
<td>4. Discussion of STIs, HIV, and AIDS risk factors</td>
<td>39</td>
<td>52</td>
<td>22</td>
</tr>
<tr>
<td>5. Informing clients that STIs increase risk of HIV</td>
<td>14</td>
<td>7</td>
<td>20</td>
</tr>
<tr>
<td>Total score (0-5)</td>
<td>1.24</td>
<td>1.68</td>
<td>0.83</td>
</tr>
</tbody>
</table>

Substantial improvements were made in the clinics in Thika district, which could reflect greater use of the BCS Plus approach, as noted above. Providers seem to be most comfortable having general discussions about STI and HIV and, to a lesser extent, discussions of some risk factors, but counseling about the clients’ personal behaviours (for example, history of symptoms or number of sexual partners) remains rare.

Table 20. Proportion of FP clients accepting to have an HIV test

<table>
<thead>
<tr>
<th>Testing-Model (Nyeri)</th>
<th>Referral-Model (Thika)</th>
<th>Pooled Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>Endline</td>
<td>Baseline</td>
</tr>
<tr>
<td>1%</td>
<td>35%</td>
<td>0%</td>
</tr>
</tbody>
</table>

As shown in the table above, both interventions were highly effective in increasing the proportion of FP clients who actually received an HIV test after consultations.
Scale-up and replication

During the dissemination of the study findings, the Ministry of Health officials recommended adopting, scaling up, and institutionalizing the testing model. Consequently, the training period for health providers was reduced from nine to eight days. By December 2007, NASCOP and DRH in collaboration with the Population Council, CDC, and APHIA II partners had trained a core group of TOTs in the integration of FP and CT activities in all provinces.

Success factors

The following factors contributed to the success of the project:

• Government leadership
• An effective commitment from stakeholders and partners
• The involvement of the line departments in the MOH in Kenya, which encouraged the partners to work with a sense of purpose and ensured that certain activities occurred quickly, including the following:
  • Development of the policy documents, guidelines, training manuals, and protocols on integration
  • Appropriate pre-training site selection
  • Appropriate TOT and service-provider trainings
  • Support from the administrations of the implementing health facilities

Lesson learned

The following lesson was learned during the course of the implementation:

• A technical committee on integration, chaired by NASCOP and DRH, was necessary for the implementation of the project

Challenges

During the course of the implementation of the programme, the following challenges were encountered:

• Occasional shortages of commodities and insecurity about the supply of FP commodities
• Staff shortage in some of the facilities
• Staff leaving for in-service trainings
• Acceptance and ownership of the process by the service providers
• Harmonizing integration materials
• Difficulties in measuring integration
Recommendations

The recommendations listed below should be followed to successfully integrate VCT into FP centers in Kenya:

- Scale up CT services for HIV within FP settings, but ensure that the quality of FP services is also strengthened. The BCS Plus approach provides one means for doing this.
- Using this model, routine provider-initiated HIV TC could be integrated with other RH services to increase access to HIV prevention and care.
- Improve access to long-term methods for FP to better meet the needs of the majority of clients who indicated that they did not intend to have another child.
- Respect and enable the client’s choice to be tested in or referred to a facility of their choosing. Make a list of all facilities offering VCT available to support this choice.
- Address issues of workload and staff numbers, including fully using the afternoon for client appointments.
- Scale up the use of BCS Plus to improve the integration of HIV and RH services.
- Make efforts to integrate FP and RH in all HIV services to achieve total integration.
- Continue to generate and share evidence for providing integration services.
- Continue to support the MOH of Kenya in its integration efforts.
- Ensure measurement of integration indicators.

References:


5. National Council for Population and Development (Kenya). Ministry of Health, Medical Research Institute Nairobi, Center for Disease Control Nairobi, ORC

**Best Practices Submission Entry Form**

Take this opportunity to share your programme’s successes, challenges, and interventions with other programme managers and organizations.

The instructions for each section are given in parentheses after each topic entry. Please read the instructions to help fill out this form. The submission form consists of four sections that are to be filled out to the fullest extent possible. You can attach additional paper if you are handwriting the information and need extra space. You should include electronic or hard copy of documents if available. To submit your programme, email this document, as an attachment, to drh@africaonline.co.ke.

Or mail this document to:

Best Practices Secretariat  
Division of Reproductive Health  
Ministry of Health  
PO Box 43319  
Nairobi, Kenya

Thank you for your time! We look forward to receiving and reviewing your information.

The Division of Reproductive Health, MOH of Kenya
Definition of some terms used in this submission form

**Demand:** Willingness and ability to purchase a commodity or service. Demand is usually influenced by prices, education, quality of care, distance from facilities, income level, and cultural and religious factors.

**Access:** An individual's ability to obtain appropriate health care services. The presence or absence of physical, economic, or cultural barriers that people might face in using health care services.

**Quality:** The extent to which the care provided is expected to achieve the most favorable balance between risk and quality, and the degree to which delivered health services meet established professional standards and judgments of value to the consumer.

**Sustainability:** Durability of project results after the termination of the external support channeled through that programme.

**Transferability:** Transferability is the process of applying the results of research in one situation to other similar situations.

**Integration:** The process of combining or uniting two or more technical areas, such as FP (FP) with maternal and child health (MCH), FP with HIV/AIDS.

**Contextual factors:** Interrelated conditions in which a programme exists or occurs.

**Replicability:** Duplication of intervention or practices that achieves similar outcomes in different settings.

**Increased utilization of RH services:** Evidence-based upward trend of reproductive health (RH) services uptake.

**Cost effectiveness:** A progressive increase in RH service uptake.

**Indicators:** Measurements that give evidence for the accomplishment(s) of the programme.
Section 1 of 4 - Summary and Written Description

Contact Information:

(Please include the lead contact person for this programme and your organization’s contact information.)

Contact Name: 

Organization: 

Address: 

Phone: 

Fax: 

Email: 

Programme Title: 

Please complete the following five sections to provide a brief explanation of the important points of your programme. You may use bullets or short text to make this as complete and concise as possible.

1. Programme Objective and Summary:

(Instruction: Provide a brief synopsis or abstract. Include the objectives of the programme.)

----------------------------------------------------------------------------------------------------------------

----------------------------------------------------------------------------------------------------------------

----------------------------------------------------------------------------------------------------------------

2a. Contextual Factors:

(Instructions: Describe the context in which the programme was carried out, stating the pre-conditions contributing to success of the programme. Include information on environmental factors that affect the programme such as political, economic, religious or geographic and socio-cultural factors. Also, discuss steps for replicating the programme in similar settings.)
2b. Has this intervention or practice been replicated or transferred to other settings?  Yes/ No

Is this intervention or practice based on a programme from a different setting? If so, explain.

Yes/ No

If YES

If No

3. Interventions:

(Instructions: List and describe the main activities the programme uses to accomplish its objectives. Who is involved and what is their role? Bullet format preferred.)

------------------------------------------------------------------------------------------------------------------

------------------------------------------------------------------------------------------------------------------

------------------------------------------------------------------------------------------------------------------
4. Monitoring and Evaluation:

(Instructions: Briefly list which methods were used for monitoring and evaluating the programme and state who conducted the assessment. List and describe your success indicators. Please indicate NA if none is available and specify current assessment stage and when information will be available.)

Baseline/End Survey:

----------------------------------------------------------------------------------------------------------------
----------------------------------------------------------------------------------------------------------------
----------------------------------------------------------------------------------------------------------------

OR Effect/Result of interventions:

----------------------------------------------------------------------------------------------------------------
----------------------------------------------------------------------------------------------------------------
----------------------------------------------------------------------------------------------------------------

Follow Up or Other Evaluation (including any other type of assessments):

----------------------------------------------------------------------------------------------------------------
----------------------------------------------------------------------------------------------------------------
----------------------------------------------------------------------------------------------------------------

Qualitative: Yes or No (If yes, describe)

----------------------------------------------------------------------------------------------------------------
----------------------------------------------------------------------------------------------------------------
----------------------------------------------------------------------------------------------------------------

Quantitative: Yes or No (If yes, describe)

----------------------------------------------------------------------------------------------------------------
----------------------------------------------------------------------------------------------------------------
----------------------------------------------------------------------------------------------------------------
5. Lessons Learned:

(Instructions: Describe any key lessons which have been compiled as a result of experiences from this programme. Indicate gaps in the programme's success, barriers to success, and factors leading to success. Please indicate NA if none is available. Bullet format preferred.)

Success factors:

Barriers/gaps to success:

Recommendations/way forward:
**Section 2 of 4 - General Information**

1- Primary Technical Area of the Programme: 

(List one topic area which best represents your programme. See chart at end of document for technical area suggestions.)

----------------------------------------------------------------------------------------------------------------
----------------------------------------------------------------------------------------------------------------
----------------------------------------------------------------------------------------------------------------

2- Additional/ Secondary Technical Areas of the Programme

(List as many additional technical areas as are applicable.)

----------------------------------------------------------------------------------------------------------------
----------------------------------------------------------------------------------------------------------------
----------------------------------------------------------------------------------------------------------------

3- Target Population(s) of the programme: 

(List the target population for this programme.)

----------------------------------------------------------------------------------------------------------------
----------------------------------------------------------------------------------------------------------------
----------------------------------------------------------------------------------------------------------------

4- Location of Programme:

Country(ies),
Districts, Regions:

----------------------------------------------------------------------------------------------------------------

5- Starting Date of the Practice: _______  6- Ending Date of the Practice _______

Year: ___________ Year: _______ Or Ongoing: _______
NB: Practice is defined to include procedures, interventions, survey or programme

7- Organization(s): (List names of the organizations that are/were involved in the programme.)

Implementers

Funders
Section 3 of 4- Results and Evidence

Please take time to thoroughly complete this important section to the best of your ability. The results and evidence reported here are the most critical factors to properly assess each practice and define it as a “Best Practice” or other practice type.

1. What were the main outcomes?

----------------------------------------------------------------------------------------------------------------

----------------------------------------------------------------------------------------------------------------

What indicators are used to evaluate the success of this programme?

----------------------------------------------------------------------------------------------------------------

----------------------------------------------------------------------------------------------------------------

----------------------------------------------------------------------------------------------------------------

(Please describe the evidence-based outcomes, including measurable indicators used and results or outputs of the practice, for example, CPR, numbers of condoms distributed, numbers of people trained.)

2. In your opinion, is this practice a cost-effective practice? ANS 1) Yes 2) No.

----------------------------------------------------------------------------------------------------------------

----------------------------------------------------------------------------------------------------------------

----------------------------------------------------------------------------------------------------------------

If ANS is yes, please indicate 1) highly cost effective 2) relatively cost effective 3) not cost effective

3. Is this practice sustainable? If so, please state reasons:

----------------------------------------------------------------------------------------------------------------

----------------------------------------------------------------------------------------------------------------

----------------------------------------------------------------------------------------------------------------
Please include any journal articles or websites with your submission. Electronic format is preferred.

Any other additional comments:

Thank you for your time!

*If you have included your contact information (email and address- Section 1: #1), you will hear from us shortly.*
# Possible Technical Areas

<table>
<thead>
<tr>
<th>FAMILY PLANNING (FP)</th>
<th>Behavior Change Communication</th>
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<tbody>
<tr>
<td>• Contraceptive Methods</td>
<td>Information Education Communication (IEC)</td>
</tr>
<tr>
<td>• Dual protection /Dual Method Use</td>
<td>• Advocacy</td>
</tr>
<tr>
<td>• Contraception and HIV</td>
<td>• Communication/Dissemination</td>
</tr>
<tr>
<td>• Integration of services</td>
<td>• Updates/Orientations and Training</td>
</tr>
<tr>
<td>Male Involvement in RH</td>
<td>• Peer Education</td>
</tr>
<tr>
<td>Post-abortion Care (PAC)</td>
<td>• Social Marketing</td>
</tr>
<tr>
<td>FANC/MIP</td>
<td>• Counseling FP/RH</td>
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<td>EOC</td>
<td>• Informed Choice</td>
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<tr>
<td>Newborn Care</td>
<td>Service Delivery</td>
</tr>
<tr>
<td>Postpartum Care (PPC)</td>
<td>• CHWs including Community-based Distribution Services (CBD)</td>
</tr>
<tr>
<td>Female Genital Cutting</td>
<td>• Midwives</td>
</tr>
<tr>
<td>Post Rape Care</td>
<td>• Health Systems</td>
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<td></td>
<td>• Traditional Health Practices</td>
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<tr>
<td>Infertility</td>
<td>• Quality of care approaches</td>
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<td>RTI/STIs</td>
<td>Management Practices</td>
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<td>RH Cancers</td>
<td>• Health Financing mechanisms</td>
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<tr>
<td>Nutrition</td>
<td>• Capacity Building</td>
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<td>Gender</td>
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<tr>
<td>HIV/AIDS</td>
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<tr>
<td>• Voluntary Counseling and Testing (VCT)</td>
<td></td>
</tr>
</tbody>
</table>
Appendix

Possible Target Populations

- General population
- Children (under age 10)
- Mothers of Infants (<1 yr)
- Women
- Men
- Women of Reproductive Age
- Youth- Boys (age 10-24)
- Youth- Girls (age 10-24)
- Parents
- Orphans
- Pregnant Women
- Urban Populations
- Rural populations
- Transient Populations
- Persons Living with AIDS (PLWA)
- Commercial Sex Workers
- Community Health Workers
- Service Providers
- Employers/Employees
- Refugees/IDPs
- Other: _______________________

SCORING MATRIX

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>SCORE</th>
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<tbody>
<tr>
<td>Replicable</td>
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<tr>
<td>Sustainability</td>
<td>20</td>
</tr>
<tr>
<td>Increased service Utilization</td>
<td>40</td>
</tr>
<tr>
<td>Cost-Effectiveness</td>
<td>10</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
Criteria for measuring the indicators

Replicable

- History of having replicated intervention elsewhere
- Using existing MOH of Kenya structures

Sustainability

- Use of MOH of Kenya structure
- Use of local resources
- Availability of skilled human resources
- Participatory stakeholders

Increased use of RH services

- Evidence-based upward trend
- Demand creation

Cost-effectiveness

- Cost involved of the intervention
- Effect and Benefits

A practice scoring 70 percent and above would qualify as a Best Practice.

Practices that score between 50-69 percent could qualify as a Promising Practice.