



Improving Uptake of Family Planning Services in Western Kenya: Evaluation Findings and Key Learnings

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With support from the David and Lucile Packard Foundation, the "Reversing the Stall in Fertility Decline in Western Kenya" project was launched in 2009 to counter stagnating and deteriorating reproductive health indicators in western Kenya. Implemented by a consortium of partners, this six-year initiative, which became known as the Packard Western Kenya (PWK) project, aimed to strengthen the supply of and generate demand for family planning services—and ultimately reduce unmet need for contraception and fertility rates—with a focus on long-acting and permanent methods (LAPM) and sustainability. This brief summarizes key findings from a mixed-methods evaluation of the PWK project.

The PWK Project Consortium

- The **African Population and Health Research Center** (APHRC) coordinated all project activities.
- **Marie Stopes Kenya** (MSK) and **Family Health Options Kenya** (FHOK) implemented project activities in Busia and Siaya Counties, respectively.
- **Great Lakes University of Kisumu** (GLUK) conducted monitoring of project activities.

During the expansion phase (2012–2015), the project also coordinated with other Packard Foundation grantees targeting specific subpopulations, including:

- Center for the Study of Adolescence (CSA)
- Forum for African Women Educationalists (FAWE)
- Christian Health Association of Kenya (CHAK)

Consortium members also worked closely with the Ministry of Health in both counties.

Challenged by an alarmingly high population growth rate at independence, Kenya became an early leader on family planning (FP) by making it an essential component of the country's development strategy. Adopting its first national population policy and FP program in 1967, Kenya went on to have a strong and successful FP program in the 1980s and 1990s, resulting in a dramatic decline in the fertility rate—from 8.1 children per woman in the 1970s

to 4.7 by the 1990s. Community-based distribution (CBD) of contraceptives, funded primarily by donors, is often credited with the concurrent and equally dramatic increases in the modern contraceptive prevalence rate (CPR). However, as donor attention and funding shifted to HIV/AIDS, funds for FP declined, compromising gains in FP service provision and contraceptive use and leading to a prolonged stall (and reversal in some areas) in fertility decline.

PWK Project at a Glance

Objective 1: Improve the supply of FP services

- Community Health Volunteers (CHVs) are recruited and trained to provide quality family planning (FP) information and counseling, and to distribute pills and condoms
- Facility staff are trained to deliver long acting and reversible contraceptive (LARC) methods and reduce contraceptive stock-outs through improved commodity management (the project provided emergency buffer stocks)
- Mobile outreaches are organized to bring a full range of FP methods, including long-acting and permanent methods (LAPM), closer to rural communities

Objective 2: Generate demand for FP services

- CHVs conduct household visits and community sensitization meetings and distribute information, education, and communication (IEC) materials
- CHVs provide referrals to facilities for reproductive health and FP services requiring medical intervention

Objective 3: Create an enabling environment for FP

- Project activities are monitored and project achievements and lessons learned are disseminated
- PWK partners engage with county government officials and other partners in dialogue on FP issues
- Advocacy activities promote county budget allocations to support FP and sustainability of project

Evaluation Goals

1. Document project implementation
2. Assess the project's influence on FP knowledge, attitudes, and practices
3. Provide insights into key factors affecting the sustainability of the project
4. Identify key learnings and recommendations for future FP programming in Kenya

“Some of us although we used to be health workers before we were trained by Packard, there were some areas where we were still shy. So Packard really enlightened us and helped us to be courageous and to talk about reality concerning sex. . . .”

- CHV

“We had been offering shallow counseling on FP at the facility, so after that training I learned how to counsel a mother properly.”

- Facility staff

In light of these trends, the Kenyan government tried to reposition FP as a development priority, making the National Coordinating Agency for Population and Development (NCAPD) a semiautonomous agency within the Ministry of Planning and National Development in 2004. It also added a new line item for FP commodities to the 2005 Ministry of Health (MoH) budget, launched a National Reproductive Health Strategy in 2007, and developed a Strategy for Improving Uptake of LAMP in 2008. During this period, the government also launched the Community Health Strategy (2006), which sought to improve access to and use of health services, including FP, at the community level. The strategy organized Community Health Volunteers (CHVs) into Community Units, linked to a health facility and supervised by Community Health Extension Workers (CHEWs). In doing so, it began phasing out the parallel CBD system that relied on CBD agents.

Against this backdrop, the PWK project was developed in 2009 as part of a larger national effort by the Kenyan government, donors, and NGOs to counter the stall in fertility decline in Kenya. The PWK project, initially launched as a three-year demonstration project (2009-2012), is a community-based FP initiative implemented in two large rural counties in western Kenya: Busia and Siaya. These counties were selected because of their high fertility rates and low CPR in 2009 and the absence of donor or other FP initiatives. From 2012-2015, project activities were intensified and scaled up in Busia and Siaya during the project's expansion phase.

PWK project goals were to (1) increase routine use of contraceptives among women of reproductive age and (2) reduce preferred family size and influence fertility intentions among women and men. The project adopted an integrated, sustainable model of FP service provision that aligns with the existing policy priorities and systems mentioned above, and addresses both demand- and supply-side barriers to increase uptake of FP services. The project has three key components: (1) improving the supply of FP services by training CHVs to provide CBD services, conducting mobile outreaches, and training facility staff, (2) increasing demand for FP services through household visits, community meetings, and distribution of information, education, and communication (IEC) materials, and (3) improving the policy environment through advocacy to promote budget allocations for FP and sustainability of the project's interventions.

EVALUATION OVERVIEW

The evaluation assessed the implementation, outcomes, and sustainability of the PWK project. It also sought to identify key lessons learned and recommendations for future FP programming in Kenya. The study relied primarily on the collection and analysis of in-depth qualitative data, triangulated with program monitoring and other secondary data. Qualitative data from female youth (ages 15-24), women (ages 25-49), men (ages 18-59), and CHVs were collected through focus group discussions (FGDs). In-depth interviews (IDIs), sometimes in groups, were conducted with CHEWs and health facility staff. Among these respondent types, 64 FGDs and 30 IDIs were conducted across 16 facility catchment areas (8 in Busia and 8 in Siaya). IDIs were also conducted with 8 county and 6 national level stakeholders, and 7 project staff, for a combined total of 114 FGDs and IDIs.

KEY FINDINGS: IMPLEMENTATION

In collaboration with the MoH, the project recruited and trained a new workforce of 600 CHVs integrated into MoH structures to deliver FP services at the community level. To support rapid scale-up and sustainability, the project leveraged existing CHVs and recruited new CHVs through local governance structures. CHVs were trained on the MoH's CHV curriculum by MoH trainers, using the basic and FP-specific modules for new CHVs and the FP module for existing CHVs. CHVs demonstrated a strong understanding of the project's goals, and felt the training equipped them with the knowledge and confidence needed to deliver FP information, counseling, and commodities. Many CHVs became passionate champions for FP, speaking openly about their own experiences with LAMP and other methods. CHVs felt supported by CHEWs and facility staff, reporting that they generally received necessary commodities and guidance.

Over 160 providers were trained on delivery of LARC methods, with some facility staff receiving training on commodity management. A seven-day training on provision of long-acting reversible contraception (LARC) was offered to facility in-charges and other providers identified by the county Reproductive Health Coordinator. Providers praised the comprehensiveness and quality of the training, believing it improved their ability to provide counseling on FP methods, while also allowing them to provide new contraceptive methods, specifically implants and intrauterine contraceptive devices (IUCDs). Facility staff also appreciated the commodity management training, though implementation of this training was more limited.

Snapshot of Key Program Outputs

CREATION OF FP WORK-FORCE

- **600 CHVs** recruited and trained to provide FP services
- **164 facility staff** trained to provide implants and IUCDs

SUPPLY AND REACH OF SERVICES

- > 400,000 community members participated in FP sensitization meetings
- > 210,000 people reached through household visits
- > 4 million condoms and >190,000 pill cycles provided through CBD
- Approximately 67,000 referrals by CHVs for LAPM
- > 31,000 clients served through outreaches
- > 153,000 couple years of protection generated by project activities

"In the past we would only get injectables, pills and condoms but the rest were not there but now you can get all the methods [at facilities]."

- Female beneficiary

"Nowadays when you go to a baraza, the chief will tell you to talk about FP. All these leaders have welcomed FP, so it has changed people's perceptions in the village."

- Facility staff

Mobile outreaches were a key vehicle for increasing contraceptive options and access, but were logistically challenging. Originally envisioned as outreach events in communities, mobile outreaches were conducted at facilities to allow for provision of LAPM. In Busia, a dedicated team of providers conducted all outreaches; in Siaya, existing facility providers were supplemented with additional MoH staff. Outreaches involved collaboration between CHVs and facility and project staff, and were logistically challenging. However, they were effective in meeting unmet demand for contraceptives. The project conducted an average of 10 outreaches per month, though frequency at a given facility varied.

KEY FINDINGS: SUPPLY OF FP SERVICES

CHVs reached a diverse clientele—including women, men, and youth—using different strategies. On average, CHVs conducted 60 household visits each month—totaling more than 210,000 visits from 2013 to 2015. One-on-one interactions helped CHVs build relationships with community members, and were appreciated for the privacy and confidentiality they offered. CHVs also used a number of community platforms—including barazas, women's and youth group meetings, churches, and theater performances—to provide FP information. CHVs held over 8,000 community meetings attended by 400,000 women and men during the project's expansion phase. Women's and youth group meetings were found to be particularly effective.

CHVs were a convenient, and sometimes preferred, source of short-term methods. CHVs provided over 4.2 million condoms and nearly 200,000 cycles of pills across 186,000 client interactions from 2013 to 2015. CBD served women, men, and youth, with CHVs employing tailored delivery approaches for different clientele, often meeting with women in secret and using euphemisms to communicate with youth. Many women noted that CHVs were their preferred or main source for FP services, due to the convenience and confidentiality CBD offered. Male CHVs were as effective as female CHVs in reaching new CBD clients and do not appear to have targeted males only.

Mobile outreaches complemented CBD by expanding access to injectables and LAPM.

Outreaches served more than 24,000 female FP clients. Women appreciated the convenience of outreach locations and that services were provided free of charge. More LAPM were provided in Busia, whereas over 7,000 males participated

in outreaches in Siaya, resulting in high levels of condom distribution.

Referrals by CHVs facilitated use of FP services at facilities, including during outreaches. CHVs acted as a bridge between communities and facilities through their provision of referrals for facility-based reproductive health and FP services. CHVs provided more than 78,000 referrals, 67,000 of which were for LAPM. Referrals expedited services at facilities and ensured that they would be provided for free. CHVs followed up with referral clients to inquire about side effects and method satisfaction.

Method mix and perceived quality of care improved at facilities, but privacy and cost concerns remain. Many women reported improvements in the quality of FP services at facilities over the last few years, noting in some cases improved availability of different FP methods. However, many women continue to have concerns about the privacy and cost of FP services at facilities, and other facility staff and community members noted that occasional stock-outs still occur, particularly of injectables.

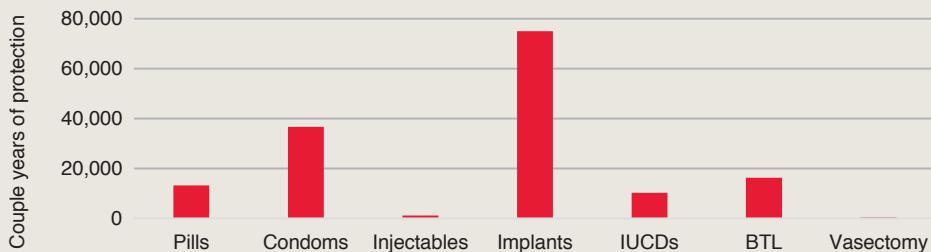
The project increased the supply of short- and long-term methods. Across the various methods provided, the project generated over 153,000 couple years of protection (CYP) from 2013 to 2015 (Figure 1). Implants provided by the project accounted for almost half of the project's overall contribution to CYP. Despite the low conversion factor for condoms (120 condoms equals one CYP), the project distributed so many condoms that they account for the second-largest share of the project's contribution to CYP.

KEY FINDINGS: KNOWLEDGE, ATTITUDES AND INTENTIONS

CHVs shifted attitudes in support of FP. The project's slogan, "Jamii ndogo: Jimudu," which conveyed the message that smaller families are easier to manage, seemed to be effective with beneficiaries. In addition, most FGD participants understood that FP can be used for spacing as well as stopping child-bearing and that use of FP can have both health and economic benefits. Beneficiaries and CHVs noted that community members and leaders encourage women to seek out the CHV and use FP services, especially if they observe that a woman has been giving birth relatively frequently.

CHV efforts to engage youth have made youth more open to discussing FP topics. CHVs tailored their strategy to reach youth, leveraging youth group meetings and meeting youth privately outside their homes. CHVs felt that, over time, it became easier and more acceptable to talk to youth about repro-

Figure 1. Couple years of protection attributable to the PWK project



Source: Authors' calculations based on APHRC Endline Report, 2016. Data from October 2012 to May 2015.

Note: Pills and condoms from CBD and outreaches, injectables from outreaches only (facility-based provision is not solely attributable to the project), all other methods from outreaches and facilities. Couple years of protection (CYP) calculated using USAID's conversion factors and 10 CYP per bilateral tubal ligation (BTL) and vasectomy.

ductive health and FP, with parents becoming more open to CHVs talking to their children about these topics. CHVs commented that male youth have a high demand for condoms to prevent pregnancy and sexually transmitted infections.

CHVs had less success in increasing male support for FP, but the project's messaging on the economic benefits of FP seemed to resonate with some men.

Despite the project's intention to target and engage men, women and CHVs observed that male support for FP is still low, with some men fearing that female methods can cause permanent infertility, birth defects, and undesirable side effects. Outside of condom distribution, CHVs' efforts to target men were not effective, with many CHVs, including male CHVs, preferring to circumvent unpleasant interactions with men during household visits. However, CHVs and beneficiaries noted that changing economic conditions and economic arguments for small families seem to be influencing some men's attitudes toward FP, and 49 men even volunteered for vasectomies.

The impressive increase in uptake of implants is one of the project's notable successes, setting project counties apart from other areas and likely driving increases in CPR.

Project activities contributed to a large increase in implant use over the course of the project. Implants accounted for almost all of the increase in the modern CPR in the project counties during the project period, while use of other methods remained essentially flat (Figure 2). In 2014, project counties also had higher rates of implant use and lower rates of injectable use than did surrounding counties, further supporting the project's contribution to increases in the modern CPR in the project areas (Figure 3).

The project helped women align their choice of FP method with their fertility intentions.

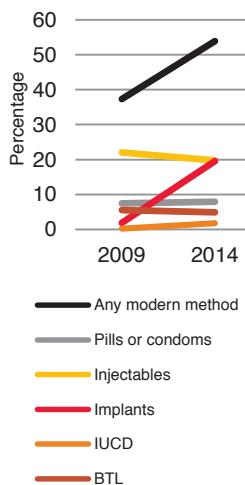
Women emphasized that CHVs and facility staff helped them choose the best method to meet their needs. Most women were able to differentiate the appropriateness of various methods by fertility intention. This appears to have translated into an improved match between women's fertility intentions and methods adopted. Implant use was more common among women who wanted to delay childbirth for at least two years, and sterilization was more common among women who did not want any more children. However, the majority of women for whom a LAMP could be appropriate still choose a short-term method.

KEY FINDINGS: USE OF FP SERVICES

Project monitoring data suggest that the project contributed to large secular increases in CPR.

During the PWK project period, Kenya experienced a dramatic increase in modern CPR and decrease in unmet need for FP and fertility rates. Nationally, the CPR increased by 14 percentage points (from 39 to 53 percent), with LAMP use rates more than doubling (from 8 to 17 percent). These dramatic changes in FP indicators were mirrored in PWK project areas and other regions of Kenya. Project monitoring data on new and repeat FP clients and their uptake of methods provide plausible evidence that the project contributed to some of this secular increase in the modern CPR.

Figure 2.
Use of FP methods



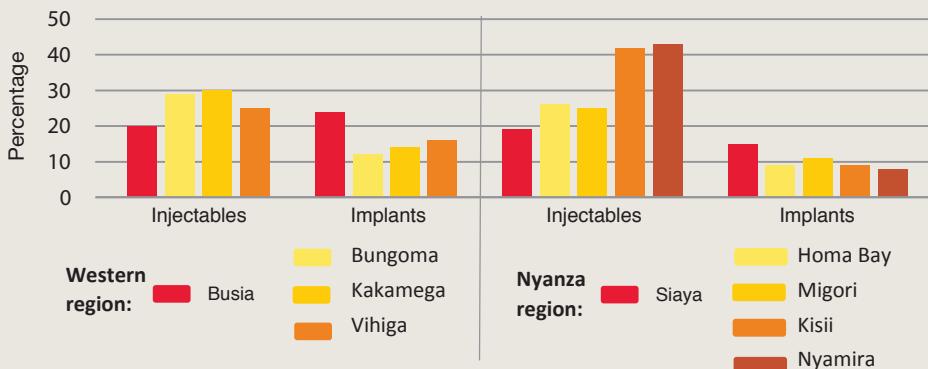
Source: 2009 data from APHRC Baseline Report, 2013. 2014 data from Kenya Demographic and Health Survey, 2014.

Note: Currently married women ages 15-49.

KEY FINDINGS: IMPROVING THE POLICY ENVIRONMENT

Devolution presented risks and opportunities for FP in the PWK project counties. Under devolution, responsibility for health budgets was transferred to newly created counties, which were expected to finance government provision of FP services.

Figure 3. Use of injectables and implants in Busia, Siaya, and other rural counties in project regions



Source: Kenya Demographic and Health Survey, 2014.

Note: Current use among currently married women ages 15-49.

"So that's why we're saying if all this [devolution] is happening, FP could lose if we don't keep the tempo, the advocacy."

- National NGO stakeholder

"Other partners come with pre-determined strategies, but Packard came with an open mind and wanted to hear from our experiences. They would place the information out there and let us critique. It was a bottom up approach."

- County MoH staff

"[Referrals] have an impact because once you give a client a referral it also gives her courage to go to a certain facility for a certain service."

- CHV

Whereas Kenya had previously self-financed 50 percent of its FP commodity costs, in the first year that counties set their own budgets for health (2013), there were no budget allocations for commodity procurement in any counties. On the other hand, because devolution allows counties to determine their own priorities, the PWK project partners saw potential for the governments of Busia and Siaya Counties to become leaders in FP, setting an example for other counties to follow.

Progress on prioritization of FP in Busia and Siaya reflects the efforts of many actors, including the PWK partners and the county MoHs. Recognizing the benefits of coordinating advocacy efforts, PWK partners worked together with CSA, FAWE and CHAK to engage county-level government and MoH officials in dialogue about their projects and FP policy and budget priorities more broadly. MoH staff credited PWK partners for their role in securing the FP line item in Siaya County's budget, but felt that other actors, especially champions within the county administration, were more influential in the decision to include CHV stipends in the county budget. In Busia County, FP and health in general do not have such strong champions; therefore progress has been slower, despite concerted efforts by partners and the MoH. Recently, the PWK partners began laying the foundation for potential replication of PWK project activities in neighboring counties by hosting advocacy meetings with government officials in Bungoma, Homa Bay, and Kakamega Counties.

The project partners used a variety of mechanisms to disseminate evidence and learning.

These include conference presentations, project reports posted on partners' websites, and journal articles. Although dissemination activities occurred

at the local and international levels, advocacy and policy engagement efforts were mainly focused at the county level. As a result, the project is not as well known among national-level stakeholders.

KEY LEARNINGS

CHV provision of FP services, including CBD, can be cost-effectively integrated into existing health system structures and processes. The project effectively leveraged existing MoH training modules and trainers, and structures under the Community Health Strategy to recruit, train, and support CHV provision of FP services. CHVs became a widely respected and used source of FP information, counseling, and short-term methods—and were well supported by CHEWs and facility staff. Although the project demonstrated that CBD can be integrated into a broader set of CHV services, multi-tasking across too many service tasks could potentially strain CHVs and jeopardize their ability to provide high quality FP services. Sustainability of the CHV FP services may require continuation of CHV stipends.

Tailored approaches are needed to reach different demographic groups with FP services. As community members, CHVs were able to create safe spaces to meet with youth and women whose husbands or families were not supportive of FP. CHVs were also able to use informal, unplanned interactions to deliver FP information and commodities.

Increasing awareness and accessibility of LAMP, particularly implants, can have a dramatic impact on uptake. CHVs and facility staff counseled women on the full range of FP options, and implants emerged as the most popular LAMP. The project used several vehicles to make LAMP services more accessible, including through referrals issued by

CHVs, outreaches (particularly in Busia), and training of facility staff (especially in Siaya).

Highlighting the economic benefits of small families can be an effective approach to shifting FP attitudes, but shifting practices may be more challenging. By emphasizing that smaller families can be easier to manage and support, and that FP can be used for birth spacing rather than just stopping childbearing, the project was able to generate support for FP among women and community leaders. The project was not able to eliminate widespread anxiety about FP leaving women infertile, and many people continue to believe that young women should marry and have one or two children before starting FP. Refined and intensified IEC efforts may be needed to build greater trust in reversible contraceptive methods.

"[FP] is just the way you can write a sentence and then put a comma, this doesn't mean full stop."

- Male beneficiary

Although men used CBD for condoms, CHVs had limited success reaching men through IEC activities, or increasing male support for FP. CHVs' pessimism about their ability to change strong and pervasive disapproval of FP among men, combined with the lack of an organized platform to engage groups of men in discussions about FP, impeded the project's success in changing the culture of male resistance to women's use of FP.

Elimination of stock-outs at facilities may require more county-level coordination and support. The project's commodity management training helped facility staff track existing inventory, but did not improve their ability to forecast commodity needs. PWK partners played an important role in reducing stock-outs by providing buffer stocks and facilitating redistribution of commodities across facilities.

Confidentiality and cost concerns continue to be barriers to use of FP services at facilities. Despite perceived improvements in the quality of facility-based FP services, women still have concerns about the privacy and confidentiality of facility services. In addition, FP services are not always provided for free at facilities, as is required by the MoH, and transportation costs and waiting times are often non-trivial.

Monitoring systems need to be right-sized to the capacity of health workers collecting the data. The project's ambitious monitoring system generated monthly data that were useful for program

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tracking and improvement, but CHVs and CHEWs noted that they spent a considerable amount of time on reporting—time that could have been used to provide services to communities. Reporting burden may also have discouraged facility staff from providing complete data.

Targeted engagement and advocacy efforts are critical for securing budget allocations for FP, but they may not be sufficient without a local champion. Despite progress in advancing the FP agenda and securing resources for FP—in part due to the advocacy efforts of PWK partners and other actors—county MoH stakeholders stressed the importance of a local government champion for securing adequate funding for FP service provision.

KEY CONSIDERATIONS

Project partners should seek county support and funding for ongoing trainings, in addition to the current advocacy on funding for FP commodities and CHV stipends. Initial and refresher trainings will be needed for replacement and existing CHVs and facility staff, respectively, to ensure high quality service provision, particularly as FP guidelines evolve and new FP methods become available.

Incorporating injectables into CBD could be a cost-effective approach to increasing the CPR.

The MoH already endorses CBD of injectables in underserved areas with high maternal mortality rates and low facility coverage. Although neither Busia nor Siaya County qualifies as a high-need area based on these criteria, allowing and enabling CHVs to provide one of the country's most popular FP methods could spur further increases in routine contraceptive use. PWK partners could advocate for broader inclusion of injectables in CBD using evidence from other parts of Kenya and the PWK project.

County MoHs should consider different approaches to outreaches. The project's demand-responsive approach to organizing outreaches was logically challenging and may not be sustainable. However, an alternative approach to facility-based outreaches, such regularly scheduled visits by MoH medical officers, may improve the potential for sustainability and help ensure that rural communities have adequate and reliable access to the full range of contraceptive options.