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An Assessment of the Policy and Programmatic Evolution of the Community-Based Distribution of Family Planning Program in Kenya and Prospects for Its Sustainability

Ruth N. Musila, Eunice Mueni

January 2014

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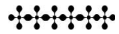

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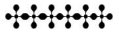

An assessment of the policy and programmatic evolution of the community-based distribution of family planning program in Kenya and prospects for its sustainability

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January 2014

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Acronyms

AFP	Advance Family Planning
APHIA	AIDS, Population and Health Integrated Assistance
CBD	Community-based Distribution
CHC	Community Health Committee
CHEW	Community Health Extension Worker
CHSU	Community Health Strategy Unit
CHV	Community Health Volunteer
CHW	Community Health Worker
CPR	Contraceptive Prevalence Rate
CU	Community Unit
DHS	Demographic Health Survey
DMPA	Depot medroxyprogesterone acetate
DRH	Division of Reproductive Health
FHOK	Family Health Options Kenya
FP	Family Planning
FPAK	Family Planning Association of Kenya
IEC	Information Education and Communication
IUCD	Intra-Uterine Contraceptive Device
JICA	Japan International Cooperation Agency
KEMRI	Kenya Medical Research Institute
KCOA	Kenya Clinical Officers Association
KOGS	Kenya Obstetrics and Gynecological Society
LAM	Lactation Amenorrhea Method
M&E	Monitoring and Evaluation
MCUL	Master Community Unit List
MDGs	Millennium Development Goals
MNCH	Maternal, Newborn and Child Health
MoH	Ministry of Health
MoPHS	Ministry of Public Health and Sanitation
NCPD	National Council for Population and Development
NHIS	National Health Information System
NNAK	National Nurses Association of Kenya
PROGRESS	Program Research for Strengthening Services
RH	Reproductive Health
SDM	Standard Days Method
SHMT	Sub-County Health Management Team
SRHR	Sexual Reproductive Health and Rights
SSA	Sub-Saharan Africa
TB	Tuberculosis
TFR	Total Fertility Rate
TWG	Technical Working Group

Background

Kenya's high disease burden, which is aggravated by high poverty levels, is faulted for slowing the country's development. Kenya has unacceptably high rates of maternal and child deaths. The country is also faced with high fertility and a youth bulge in its population age structure, which has implications on job creation and socio-economic development. The far-reaching benefits of family planning (FP) are increasingly being recognized as contributing to health, economic, and environmental benefits.[1] FP use reduces unintended pregnancies by helping women delay births, lengthen birth intervals, and enable women who want to stop childbearing do so.[2] However, currently, about a quarter of married Kenyan women (26%) have an unmet need for FP (they would like to delay the next birth or stop childbearing altogether but are not using any method of contraception).[3] Further, this unmet need is highest in the poorest women. This implies there is a potential to increase contraceptive use and reduce fertility amongst the most underserved groups.

Contraceptive use levels are influenced by availability and accessibility of FP services. The latter is defined as the extent to which services are available and can be obtained by those seeking the services.[4] It is estimated that over 70% of Kenya's population lives in underserved rural areas where many women do not have adequate access to FP services. To address these issues, more attention in needed on improving access to contraceptives specifically among the rural and the underserved population with high fertility rates and child deaths.

Given the dearth of healthcare facilities and providers in many sub-Saharan Africa (SSA) countries,[5] one way to address geographical and financial barriers to accessing modern FP commodities is the establishment of community-based distribution (CBD) programs. CBD is defined as "programs of non-clinical FP service approaches that use community organization, structure, and institutions to promote the use of safe and simple contraceptive technologies."[6] The CBD program is reliant on members of the community who often work on a voluntary basis and under supervision. Even the lowest cadre of community health workers (CHWs) are trained to provide FP services, information and carefully selected/defined FP products in homes and public places (e.g. community outreach events) as well as referrals for clinic-based services.

A pioneer country of the CBD program in Africa, Kenya adopted the CBD strategy in the early 1980s in an attempt to increase use of modern contraceptives, becoming one of the leading countries in SSA to develop and implement a CBD program. In the wake of rapid population growth, the government recognized the need to manage it and was convinced by existing evidence that CBD was one of the strategies that would result in increased contraceptive use.[7,8] In addition, with a severe shortage of health care providers, coupled with a limited number of health facilities, particularly in hard to reach areas, CBD programs had been credited for enhancing access to underserved communities in Africa, Asia and Latin America.[9]

Box 1. The evidence on CBD programs from Asia, Africa and Latin America

- There is a need for reproductive health (RH)/FP services, particularly in rural and underserved areas
- CBD programs can increase and sustain FP use, especially in areas with high unmet need for FP
- CBD programs can help increase acceptability of FP, particularly in traditional societies
- Clients accept both male and female CBD agents
- The long-term effect of CBD programs on fertility remains unclear due to non-universal coverage and lack of clarity of appropriate indicators of success
- The cost effectiveness of CBD is variable due to differing models

Source: FRONTIERS, FHI and Advance Africa, 2002[10]

The first CBD program was started in 1982 by Family Health Options Kenya (FHOK, previously known as Family Planning Association of Kenya, FPAK) in association with the Kenya Ministry of Health (MoH) and Pathfinder International. Other players, including Chogoria Mission Hospital (a church-based hospital), *Maendeleo ya Wanawake* Organization, GTZ (now GIZ) and Nairobi City Council, also established CBD programs in the following years. Despite the establishment of the National Council for Population and Development (NCPD) in 1982 to formulate relevant population policies and strategies and to ensure effective coordination of all population-related activities in the country including all CBD activities, the programs were not harmonized. They varied in the strategies they applied such as geographical coverage, number of CBD agents, catchment areas served by the CBD agents, links with clinics, requirements for a medical examination for new pill clients, range of services provided by agents, and status, remuneration, recruitment and supervision of CBD agents. A map of CBD programs in Kenya from inception to present day is provided in appendix I.

Initially, CBD agents in Kenya provided only information on health-related topics, but from 1982, the MoH authorized volunteers to distribute contraceptives in the community. The methods provided by CBD agents were condoms, pills, and vaginal spermicidal foaming tablets, and they counseled and referred clients for long-term methods, in addition to providing information on the benefits of using FP to women and their children and for economic development.[11]

The CBD program is credited for the high uptake of contraceptives in the 1980s and early 1990s and the rapid drop in fertility during the same period. This is because it helped to overcome serious obstacles, such as women's lack of knowledge of available services and the time and cost constraints they faced in visiting FP clinics. Many studies that have evaluated Kenya's CBD program have confirmed that it enabled more women to use FP services, including those in underserved and rural areas.[12,13,14] However, towards the end of the 1990s, funding for the CBD program and national FP program declined as attention shifted to the HIV/AIDS epidemic.[15,16] With no systematic guidance offered by the MoH for the CBD operation, most of the CBD programs were closed or shifted to providing home-based care for people living with HIV/AIDS. The drastic decline of the CBD program coincided with the stall of contraceptive uptake and the fertility rate witnessed in the early 2000s, as most of the people who had relied on CBD agents for FP information and supplies no longer knew where to get their supplies from, and also because the nationwide information, education and

communication (IEC) campaigns advocating for small families and the use of contraception collapsed.

In recent years, the Kenyan government, with leadership from NCPD, organized the National Leaders' Conference on Population and Development in 2010 with the sole purpose of repositioning Kenya's FP program and addressing broader population issues in Kenya. One of the strategies to do so was to revive CBD of contraceptives. NCPD had become a semi-autonomous government agency under the Ministry of Planning and Economic Development in 2004 (now Ministry of Planning and Devolution), and had been given a new advocacy mandate, which considerably improved its effectiveness and its policy influence in population issues. The government also set a contraceptive prevalence rate (CPR) target of 56% in 2015 and 70% in 2030.[17] To achieve this, several policies and strategies have been developed (see the Policy Analysis section). A budget line for contraceptives was established in 2005, signifying political will and commitment for FP.As a result, even today FP commodities are provided at no cost in Kenya. Specifically with regards to CBD of FP, the *Community Health Strategy (2006)* involved phasing out the CBD agents and recognizing the fact that CHWs had a balanced curriculum to provide FP and maternal, newborn, and child health (MNCH) services. The MoH defines CHW as "a person chosen by his/her own community through the Community Health Committee and trained on health and development issues to act as a community mobilize and motivator for positive change." The strategy changed the focus of delivery of healthcare services including provision of FP services from health facility-based to community-based. It also provided clear guidance on facilitative supervision of CHWs.

Several isolated community-based programs have been implemented, specifically in Nyanza and Western Province.[18,19] These programs trained community midwives, who were mainly retired or out-of-work midwives, to offer a mix of services to the community including MNCH services, FP, and HIV/AIDS home-based care. An assessment of a community midwifery pilot project implemented in 2005 and scaled up in 2007 to four districts showed that, six months after their training, the community midwives were providing one tenth of all injectables and one fifth of all contraceptive pills distributed in one of the implementation districts.[20] In another study that extended the community midwifery project into other districts within Western Province, the results showed improved clients' access to a comprehensive package of RH/HIV including long-term FP methods. The number of clients receiving intra-uterine contraceptive devices (IUCDs) from community midwives more than doubled while the number of clients receiving contraceptive implants increased 20-fold between 2010 and 2011.[21]

A rapid assessment conducted by FHI 360 and the Division of Reproductive Health (DRH) (now Reproductive and Maternal Health Unit), however, found that challenges for CBD programming included low motivation among CHWs, the absence of a harmonized training focused on FP, and lack of male involvement.[22] The assessment and results led to the development of a new stand-alone module for FP within the revised national Integrated Curriculum for Training CHWs in Kenya, in collaboration with the Division of Community Health Services (now Community Health Strategy Unit, CHSU). Currently, all CHW programs are implemented by various implementing partners in line with MoH policies. The implementing partners of the CHW programs include GIZ, MYWO, Mkomani Clinic Society, FHOK, Marie Stopes Kenya, Pathfinder International, JHPIEGO, AMRE,F and FHI 360.

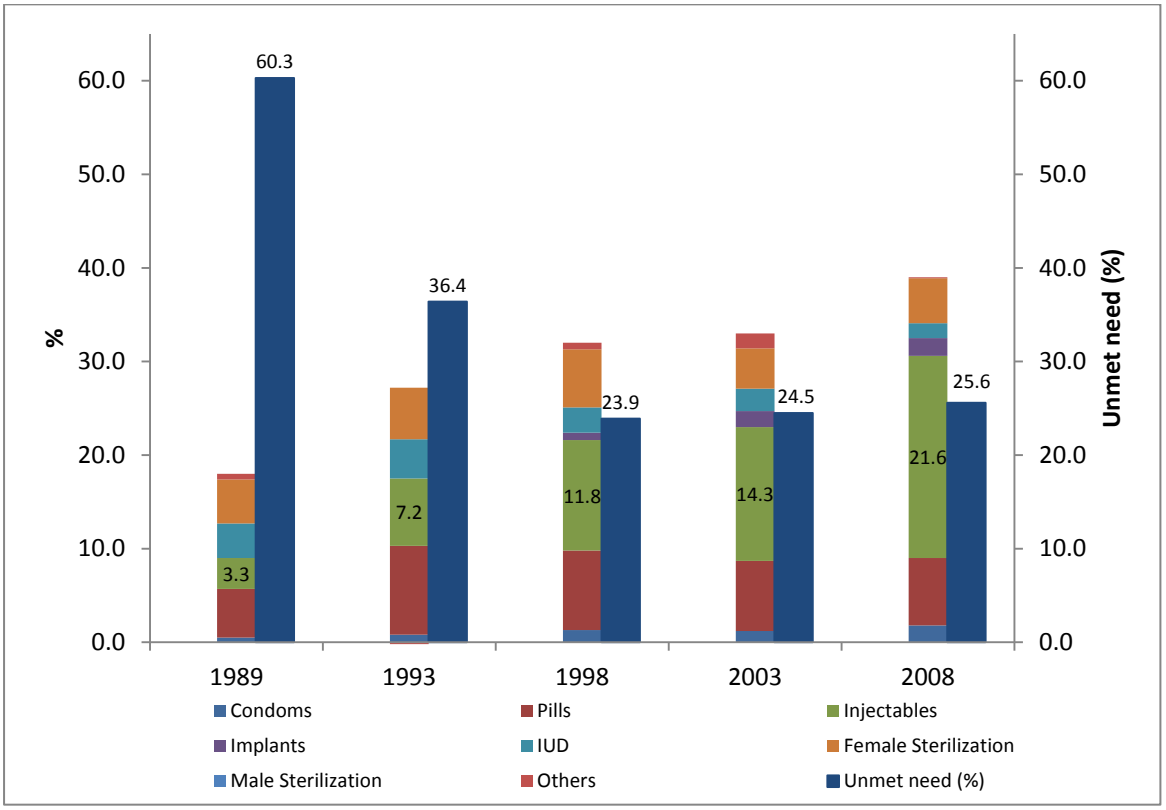
Despite these efforts, CPR levels registered in the most recent Kenya Demographic Health Survey (DHS) (2008/9) for modern methods is still low (39%), and about a quarter (26%) of married Kenyan women have unmet need for FP (figure 1). Even if the country were to meet its goal of 52% modern CPR by 2015, it is still is far from the MDG 5B target of universal access to RH by 2015.Further, the fertility rate has stagnated at about 4.6 children over the last decade, which will continue fuelling the rapid population growth and youth bulge in the country.

Figure 1. Trends in fertility, contraceptive uptake and unmet need for FP in Kenya.

Access to FP remains inequitable, with higher rates of unmet need for FP and thus higher unintended pregnancies and higher fertility amongst women in rural areas than their counterparts in urban areas. Further, the human resources for health crisis demanded innovative mechanisms such as task shifting to address this. Kenya was among the countries that made commitments at the FP2020 summit in 2012[23] whose aim is to reach 120 million women and girls in the world's poorest countries with voluntary access to modern contraceptive information, services and supplies by 2020. The government pledged to protect women's rights to access and use FP by securing additional financial resources and implementing strategies to reach the poorest and hardest to reach segments of the population. In the same year, Kenya amended its *National Family Planning Service Provision Guidelines (2010),* allowing trained CHWs to offer injectable contraceptives at the community level in marginalized areas.[24] Injectables are the most popular method among married women in Kenya, and the proportion of women using injectables has increased over time as shown in figure 2. It is expected that task shifting of injectable contraceptives to CHWs to widen contraceptive choices will go a long way to improving accessibility to contraceptives among women from all socioeconomic

backgrounds, when undertaken as a component of a complex intervention that includes fostering demand as has been the case in a number of SSA countries.[25,26,27]

Figure 2. Contraceptive uptake trends by method and unmet need for FP.



A number of in-depth assessments of Kenya's CBD program until 2000 already exist.[28,29,30] The aim of this study is, therefore, to document the evolution of policy and program processes related to CBD of contraceptives in Kenya from 2000 to present day. A comprehensive assessment will enable us to determine associations of its influence on use of modern contraceptive methods since inception, as well as determine its sustainability.

Research questions

Specific research questions that this study sought to explore in order to gain insights in the evolution of policies that govern the CHW program in Kenya and their implementation were grouped in five thematic areas, as follows:

Policies

1. Which policies have governed Kenya's CHW program, particularly with regards to FP, and what ignited the documented policy changes?
2. What are the specific policy and programmatic changes pertaining to the restriction of supply of depot medroxyprogesterone acetate (DMPA) injectable contraceptives and their timeline?

Which organizations or individuals opposed this policy change, what were their concerns, and how have these concerns been addressed?

Policy implementation

3. What are the characteristics of Kenya's CHW program?
    i. Service delivery models: What are the links to health facilities, referral process for clients, and range of services provided by CHWs?
    ii. Access to health services: What is the geographical coverage, number of CHWs, catchment areas, FP methods authorized for CHW supply or re-supply, service fees or cost-sharing mechanisms?
    iii. Personnel recruitment, training and supervision: What are the recruitment and minimum education level requirements, content of CHW training curriculum and duration of training, remuneration/compensation (monetary and non-monetary)?
    iv. Quality of care and governance of the CHW program: What is the supervision mechanism of CHWs, defined quality of care standards and means to ensure them?
    v. Implementing partners: Which organizations are running CHW programs in conjunction with the government's program and what are their characteristics?

Outcomes

4. What is the association between the CHW program and contraceptive use in Kenya?

Sustainability

5. What are the implementation challenges of the CHW program?
6. What are the future plans for Kenya's CHW program and prospects for its sustainability?

External lessons/knowledge sharing

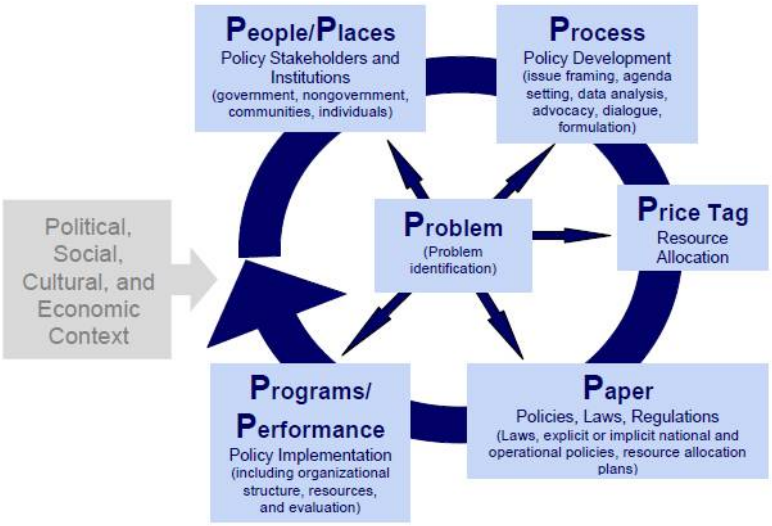
7. What can Kenya learn from the successes of CHW programs in other SSA countries?

Methods

The study used a triangulation of methods, namely, (1) literature review and review of policy and program documents, (2) key informant interviews, and (3) analysis of DHS data to answer the research questions.

Hardee *et al*'s (2004) policy circle framework[31] was used to develop the policy analysis narrative. It highlights the six "Ps" of policy: Problem, People/Places, Process, Price Tag, Paper, and Programs/Performance, which unfold according to local politics and socio-economic contexts. Notably the framework is non-linear, nor circular, and places the problem or issue to be solved at the center.

Figure 3. Policy circle framework.



Source: Hardee et al 2004.

The development of a semi-structured interview guide (see appendix II) was informed by the desk review and approved by the Ethical Review Committee of the Kenya Medical Research Institute (KEMRI) (Ref. KEMRI/RES/7/3/1). Further, consent was obtained from all respondents prior to interviews. The list of key informants is provided in appendix III.

The authors conducted a thematic analysis of the transcripts and derived descriptive themes based on the interview guide framework and discussed them iteratively to produce a final set of descriptive themes that are the basis of this report.

Descriptive analyses were used to examine trends in fertility, CPR and unmet need for FP and to assess the linkage between sourcing contraceptives from CBD agents using Kenya DHS data between1989 and 2008-09. The following outcomes were examined:

- levels of CPR over time, segregated by short-term methods (condoms, pills, injectables) and long-term and permanent methods (implants, IUD, sterilization, male and female sterilization);
- levels of CPR over time, segregated by socio-economic and demographic characteristics (place of residence, household wealth, education level);
- CPR and total fertility rate (TFR) trends; and
- percentage of women who source modern contraceptive methods from CBD agents (1989 data not available).

A correlation index was computed to test the association between TFR and CPR levels against levels of contraceptives obtained from CBD agents. We also present percentage of teenagers who had have entered parenthood stage (teenagers who are either currently pregnant or have children).

All findings from the document reviews, key informant interviews and data analysis were synthesized to develop this report and emergent recommendations.

Results

Data Analysis

The TFR sharply declined between 1989 and 1998, then stagnated between 1998 and 2003, and experienced a gentle decline between 2003 and 2008-09 (see figure 1).

Table 1. Trends in Levels of Contraceptive Use (Modern Methods) Segregated by Residence, Socio-economic Status (SES) and Education Level

CPR		1993 DHS	1998 DHS	2003 DHS	2008-09 DHS
Total		27.3	31.5	31.5	39.4
Residence	Urban	37.9	41	39.9	46.6
	Rural	25.4	29	29.2	37.2
Household wealth index	Lowest	10.3	12.6	11.8	16.9
	Second	15.7	24.1	24.2	33.4
	Middle	27.3	30.7	33.4	43.2
	Fourth	37.5	39.7	41	50.4
	Highest	45.1	50.1	44.5	47.9
Highest educational level	No education	15.3	16.1	8	12
	Primary	25.6	28.2	28.8	38.3
	Secondary or higher	44.9	46.3	51.7	52.1

Table 1 shows the level of modern contraceptive use in Kenya, disaggregated by residence, SES and education level. The results show that contraceptive use increased from 27% in 1993 to 39% in 2008-09. Results also show lower contraceptive use amongst women residing in rural areas compared to those residing in urban areas. The use of contraceptive amongst women of the highest SES is about three times higher that of women the lowest SES bracket. Similarly, households that are headed by those with at least a secondary education have a higher likelihood to use contraceptive (four times) compared to households headed by individuals with no education.

Figure 4. Trends in modern contraceptive methods in Kenya between 1989 and 2008-09.

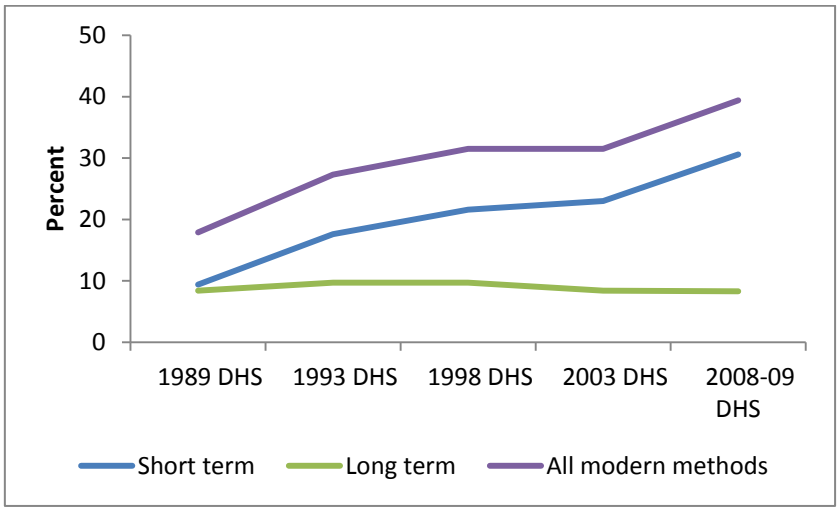
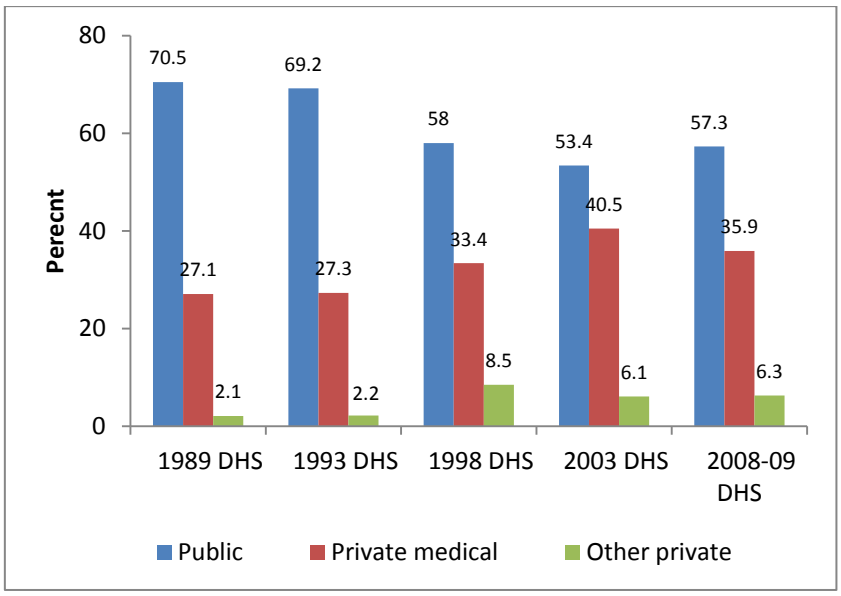


Figure 4 shows that short-term methods (condoms, pills, injectables) have driven increases in contraceptive use when compared to long-term and permanent contraceptive methods (implants, IUD, sterilization, male and female sterilization).

To assess the observed trends on CPR and unmet need for FP, we computed the percentages of users by the place where they sourced their contraceptive services across the five time points in order to uncover the trends and assess the patterns. We then narrowed down the computation to the percentage of users who obtained contraceptives from CBD agents and computed correlations using STATA software Version 12.

Figure 5. Trends in sources of contraceptives in Kenya between 1989 and 2008-09.



The data show that most contraceptive users obtained their contraceptives from public health institutions, although levels declined gradually between 1989 and 2003. On the other hand, the provision of contraceptives from private health facilities increased between 1989 and 2003. Current DHS data (2008-09) show that the marginal decline (4.5%) in users sourcing contraceptives from private facilities was matched by a similarly marginal increase (3.9%) in users sourcing contraceptives from public health facilities.

Figure 6. Trends in percentage of contraceptive users who source contraceptives from CBD agents

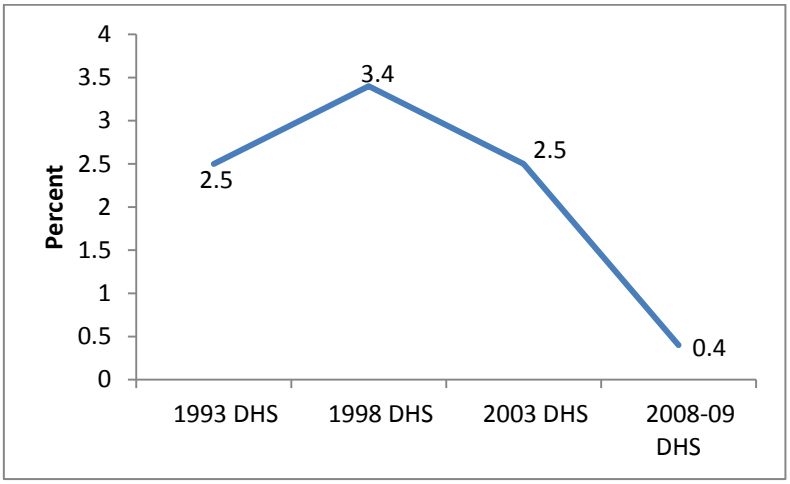


Figure 6 shows the proportion of users who obtained contraceptives from CBD agents. The range is between 3.4% in 1998 and 0.4% of women using contraceptives in 2008-09. The results also show a slight increase between 1993 and 1998 and a significant decline between 1998 and 2008-09. These findings are consistent with policy and programmatic changes that occurred in Kenya. Specifically, Kenya's fairly successful FP program stalled, whilst the CBD program collapsed in the late 1990s with the funding shift to HIV/AIDS and other national priorities. Notably, the impact of the *2006 Community Health Strategy* is not captured by these data as its implementation was delayed. It is expected that the imminent DHS may shed light on this.

In order to assess the association between fertility levels, contraceptive use, and levels of unmet need for FP against the levels of contraceptives obtained from CBD agents, we performed a correlation analysis among the five variables to understand the nature of correlation.

As expected, a significantly negative correlation (-0.94) was observed between TFR and CPR levels, indicating that the fertility decline between 1989 and 2008 was driven by the steady increase in CPR over the same time period. A sharp decline in fertility was observed between 1989 and 1998, which was mirrored by increasing contraceptive use. This was followed by a stall that was mirrored in both indicators between the 1998 and 2003 time points, and then a marginal increase in contraceptive use which coincided with a marginal fertility decline (see figure 1).

There is a positive correlation (0.96) between TFR and unmet need. This indicates that as fertility declined, unmet need for FP simultaneously declined. As noted above, the decline in TFR was driven by the consistent current users of FP. The decline in unmet need for FP doesn't necessarily imply an improvement in FP service delivery, but rather, it may be attributed to poor sensitization of potential new users, resulting in low or unchanged demand for FP. Based on current CPR levels, we would expect a drastic decline in unmet need to coincide with reduced fertility as unmet need for FP is met.

The results show a significantly high negative correlation (-0.80) between the proportion of women who sourced contraceptives from CBD agents and CPR levels. This indicates that as contraceptive use increased, users opted to obtain their contraceptives from sources other than CBD agents. This implies that as the CBD program weakened, contraceptive users obtained FP commodities from other sources.

There is a positive but weak correlation between TFR and sourcing from CBD agents (0.33). This weak association may be attributed to users sourcing contraceptives from sources other than CBD agents.

A moderately weak but positive correlation (0.39) is evident between levels of unmet need for FP and proportion of women sourcing contraceptive methods from CBD agents. This may be attributed to weakened demand creation which coincided with the collapse of the CBD program.

Notably, a limitation in the correlation analysis is availability of only 4 or 5 data points.

Figure 7. Trends in percentage of teenagers who had children or were currently pregnant.

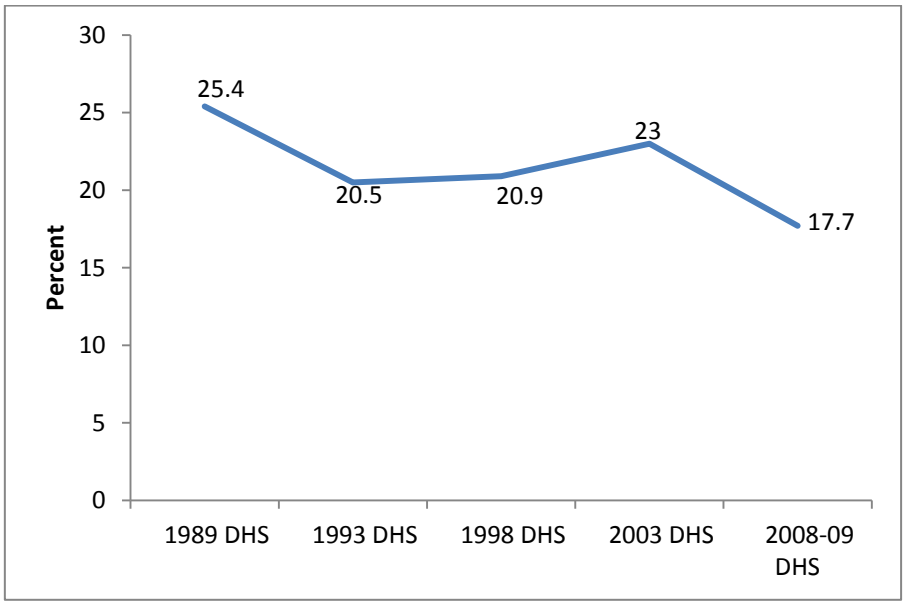


Figure 7 shows the levels of teenagers who had children or were currently pregnant during the survey. The results shows mixed patterns with the highest levels (25%) in 1989 and the lowest levels (18%) observed in 2008-09. This reinforces the need for RH/FP services that meet the needs of young people.

Policy Analysis and Igniters of Policy Change

The *Kenyan Constitution (2010)* and Kenya's development blueprint, *Vision 2030* (developed in 2008), embrace universal access to health care through community involvement. The Constitution upholds health and RH as a human right. Notably, it introduced a devolved system of government to enhance access to services, particularly in rural and hard to reach areas, which came into being in April 2013.

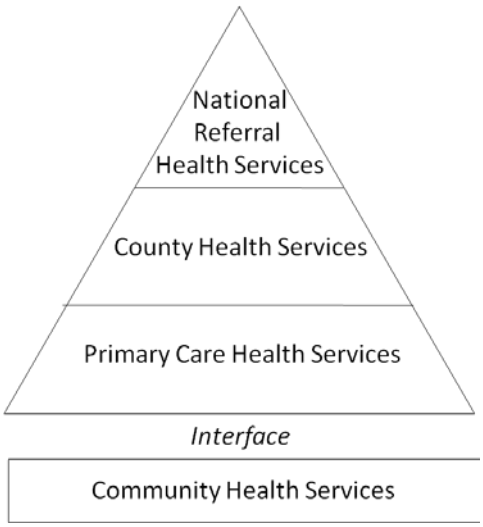
Through *Vision 2030*'s social pillar which includes health (others are economic and political), it sets out a strategy to improve livelihoods of Kenyans through provision of an efficient and high quality health care system through: (i) delinking service delivery management from the MoH, leaving oversight through policies and research;(ii) devolution of funds and management of health care to the communities and health care experts; and (iii) shifting the bias of the national health bill from curative to preventive care.

The *Health Policy 2012-2030* is an implementation framework for the health reforms outlined in *Vision 2030* and its implementation is within the conducive legal framework set out by the Constitution (see figure 8).

A number of policies guide RH/FP service provision in Kenya. The *National Reproductive Health Policy (2007)* endorsed Kenya's commitment to the achievement of all relevant international development goals and targets relating to sexual reproductive health and rights as well as identifying

priority actions aimed at reversing negative effects linked to poor RH outcomes. It provides a framework for equitable, efficient, and effective delivery of high-quality RH services country-wide, emphasizing people in greatest need and most vulnerable.

Figure 8. Levels of the health system in the devolved government.



Source: Kenya Health Policy (2012-2030)

The *National Population Policy for National Development (2012-2030)* aims at providing high quality of life for all people by managing population growth. This will be achieved through reducing population growth rate and the fertility rate. FP has been identified as one of the measures to address critical population issues and several measures have been recommended to achieve the CPR target. These measures include expanding FP service delivery points including CBD, promoting male involvement and participation in FP, ensuring appropriate contraceptive method mix and commodity security, strengthening integration of FP and other health services and intensifying advocacy for increased budget allocation.

The *Adolescent Reproductive Health and Development Policy (2003)* was a broad policy developed to mainstream health and development issues for adolescents and aimed at enhancing the implementation and coordination of programs that address the RH and development needs of young people.

The *FP Costed Implementation Plan (2012-2016)* comprises the key costed priorities that will lead to the attainment of the CPR target. The plan serves as a powerful advocacy tool for FP, as well as a guide to stakeholders on what areas to support, and was also designed as a monitoring tool for the FP program.

The *National Contraceptive Commodity Security Strategy (NCCCS) 2007–2012* provides a framework to tackle the challenges of commodity security by focusing on several components, including coordination, commitment, financing, capacity, and client demand and utilization. It seeks to ensure uninterrupted and affordable supply of contraceptives to all people that need them, whenever and wherever they need them.

Prior to 2006, health care services were mainly facility-based and focused on curative care. The MoH's second *National Health Sector Strategic Plan (NHSSP) 2005–2010* shifted emphasis from "burden of disease" to the promotion of the individual and community health. This strategic plan proposed the *Kenya Essential Package for Health*, which outlined the community strategy for healthcare delivery.

The objective of the *Community Health Strategy (2006)* is to help Kenya achieve improved health and development outcomes by enhancing community access to preventive and simple curative services at the community level. It defines the community-based approach as "the mechanism through which households and communities take an active role in health and health-related development issues", thereby establishing the community as the foundation of the national health system (level 1). The strategy redefined the CBD program and established generic work for CHWs vested with all health skills — FP, HIV/AIDS, malaria, and MNCH. The strategy is currently undergoing revision.

The *National FP Guidelines (2010)* define the FP services that can be provided by CHWs. These include counseling and provision of condoms (male and female), pills, lactation amenorrhea method (LAM), and standard days method (SDM) as well as counseling and referral for all other FP methods (including longer term methods such as injectables, implants, IUCDs and permanent methods).

Historically, CHWs were not allowed to provide DMPA injectables, the most popular contraceptive in Kenya. However, global evidence showed that lay health workers can safely and effectively administer injectable contraceptives, and can therefore target hard to reach and underserved populations with FP information and services, which has resulted in global guidelines.[32] Further, the critical health workforce shortage in the country with few nurses in these areas compounded the problem. In order to address this issue, in 2012 the MoH amended the FP guidelines to allow trained CHWs to provide injectable contraceptives in defined hard-to-reach and underserved areas where women have little or no access to clinical services from highly trained health care providers.

This policy change was as a result of collaborative efforts between different stakeholders including FHI 360, JHPIEGO, the Advance Family Planning (AFP) project[a], and the MoH. FHI 360 was implementing the Program Research for Strengthening Services (PROGRESS) project, whose aim was to improve access to FP methods and services among underserved populations in developing countries through research, research utilization and capacity building.[33] One of the strategies to achieve this was promoting the provision of injectable contraceptives by CHWs. This method has multiple advantages for users over other short-term methods including discretion if women do not want their sexual partners to know that they are practicing contraception, convenience of non-daily use (administration is every three months) and acceptability of progestogen-only injectables earlier in the post-partum period by lactating mothers. Further, injectable contraceptives don't require special skills like other long-acting reversible methods (IUCDs and implants).

However, the idea was not popular with the MoH and the professional associations — National Nurses Association of Kenya (NNAK), the Nursing Council and Kenya Clinical Officers Association

[a] AFP is based in the Bill and Melinda Gates Institute of the Johns Hopkins Bloomberg School of Public Health. In Kenya, AFP is implemented through JHPIEGO.

(KCOA). The healthcare professionals were hesitant due to safety and quality of care concerns. In the Kenyan health service, nurses are the lowest cadre authorized to provide emergency contraceptive pills, injectables, implants and IUDs, whilst clinical officers perform tubal ligations and vasectomies. A targeted advocacy strategy, led by AFP, was therefore required to alleviate the concerns of all stakeholders. Advocacy messaging to MoH focused on the impact access to contraceptives would have reducing the maternal mortality rate, as well as adolescent pregnancies, whilst that to the healthcare professionals capitalized on their work overload and the ability for regulated task shifting to create room for them to perform more specialized care. The health facility staff in the implementation site, especially nurses, resisted CHWs providing injectables. A key informant also noted that the nurses were afraid of losing respect in the community. The directors of Medical Services and Public Health and Sanitation, DRH, and the chief nursing officer bought into the idea after evidence on the effectiveness of CHWs providing injectables was presented to them. After buy-in from the government, they convinced the health care professional associations to support the policy change.

A key approach of the advocacy strategy was a study tour in Uganda in 2006 to learn from their program. Uganda had changed its policy to allow trained CHWs to provide injectables in 2010. The advisory committee led by DRH consisted of representatives from medical associations (NNAK, Nursing Council, Kenya Obstetrics and Gynecological Society (KOGS), and KCOA) and other partners (FHI 360). After the study tour, local evidence was needed to make the case for its feasibility in Kenya. FHI 360 led the implementation of a demonstration project in Tharaka in 2009. Tharaka was chosen as the implementation site because a CHW program was already ongoing (although the CHWs were not providing injectables). As FHI 360 is not an implementing organization, they worked with JHPIEGO who were an implementing partner of the AIDS, Population and Health Integrated Assistance (APHIA II) program in Eastern province. After one year of implementation by JHPIEGO, the results showed that that it was feasible, effective and safe for CHWs to offer injectables.[34] JHPIEGO, through AFP, coordinated the final stages of the advocacy efforts toward policy change with researchers, healthcare providers, and policymakers. Critically, it was recognized that evidence is not that sole factor in decision making and therefore a multi-pronged advocacy strategy that included all stakeholders was employed.[35,36]

The successful implementation of the pilot and the positive findings showing increased injectable contraceptive uptake, in addition to generally improved SRH indicators in the implementation site provided a strong basis on the need to allow CHWs to offer injectable contraceptives. Despite this, a 2012 study that was conducted by the Ministry of Public Health and Sanitation (MoPHS) to assess FP community services in Kenya, found that the Nursing Council favored use of nurses to provide injectable contraceptives, rather than CHWs,[37] implying the need for continued advocacy to alleviate safety and quality of care concerns.

> *Professional associations were very much against [the policy change], especially the Nursing Council. Initially they did not want to talk about it, but with dedicated advocacy they agreed to come to the negotiating table and we presented the evidence. The resistance was quite intense and even at the time of policy change, the nurses were still not on board, so advocacy still continued.*
>
> — Implementing agency representative

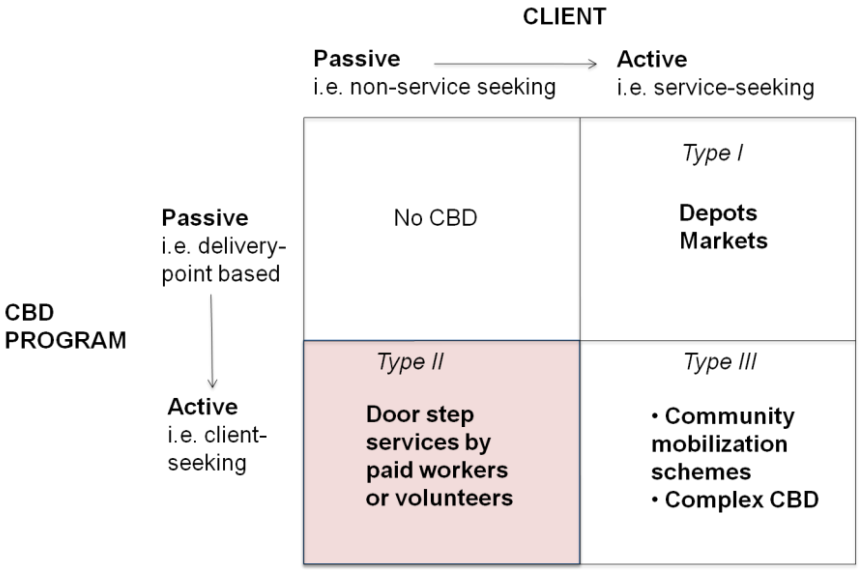
Implementation of the CHW Program

Characterization and governance of the CHW program in Kenya

The Community Implementation Team consists of three key players in administrative units known as **Community Units (CUs)**: **CHWs**, **Community Health Extension Workers (CHEWs)** and the **Community Health Committee (CHC)**, whose functions are elaborated below.

The CHW program of Kenya's Community Health Strategy is a Type II model,[38] which is characterized by active service provision in the form of household visitation by CHWs.

Figure 9. Typology of CBD models.



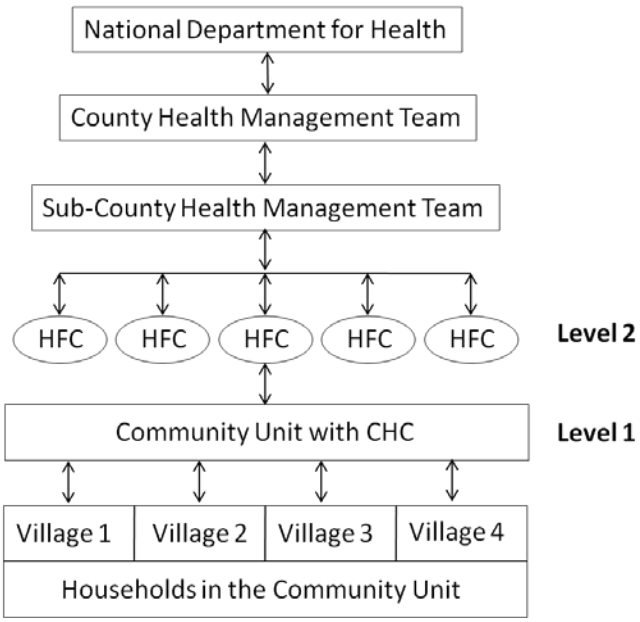
Source: Phillips et al, 1999.

The CHWs are organized into CUs, which are composed of about 5,000 people and a CHC. CHWs in each CU are supervised by two CHEWs, who are in turn linked to a health facility, where clients may be referred. The CHEWs are hired and paid through the local Health Facility Committee and are trained and supervised by the District Public Health Officer and District Public Health Nurse per district, and each trained CHEW is expected to supervise 25 CHWs.

Each CU is governed by a CHC that is trained on the Community Health Strategy and consists of a chairperson (community member), secretary (CHEW) and treasurer (CHW). CHCs oversee the operations of level 1 health services in the community by actively participating in recruitment and supervision of CHWs, discussing community data with CHWs and reviewing community action plans in order to tackle specific health issues that have been identified in the community. CHCs are the link between the community and the health facility. CUs therefore encourage community responsibility of their own health and enable the regulated provision of a range of services at the community level. An electronic database of CUs, the Master Community Unit List (MCUL)[39] was established to monitor community services and strengthen the national health information system (NHIS). The number of CUs in June 2012 was 2,511 and about 3,200 in October 2013, still far from the national target of 8,726 CUs by 2017.[40]

The restructuring based on the new devolved system of governance of Kenya has seen the Division of Community Health Services changed to the Community Health Strategy Unit which sits in the Division of Family Health (formerly Family Health Department).[41] Further, with the establishment of Community Health Services in the 47 county governments, the implementation of the Community Health Strategy in the counties has been revised as follows.[42] A **Health Facility Committee**, which includes membership of the chairperson of the CHC to represent the interests of the community. The role of this committee is to incorporate the Annual Work Plan from the CHC and forward it to the **Sub-County Health Management (SHMT) Team** (which has replaced District Health Management Teams). A **Sub-County Community Health Strategy Focal Team** will provide supportive supervision of the CUs and ensure successful implementation of the Community Health Strategy. Notably, the number of CHEWs per CU has been revised to five; therefore recruitment is required to obtain a total of 43,630 CHEWs. There will also be a **County Community Health Strategy Focal Team** providing oversight of community health strategy activities in sub-counties. Policy and strategic oversight will remain at the national level, in the MoH (now known as the Department for Health).

Figure 10. Community service provision linkages to county and national levels.



Adapted from: Ministry of Health, Division of Community Health Services.

Geographical coverage of CHWs

The assignment of CHWs to households was initially solely based on population density nationwide at one CHW to 20 households (equivalent of 50 households), but was later revised based on the country's heterogeneous population density to incorporate four socio-economic regions as outlined in table 2.

CUs are currently being established where there is need. Areas with low CPR are not given extra attention and support *per se*; however, the policy change that allowed CHWs to administer injectable contraceptives and therefore improve method mix targets hard-to-reach areas.[43]

Table 2. Geographical Coverage of CHWs in Kenya

Socio-economic region	Population density	No. of people per CHW	Equivalent # of households	Regions
Nomadic	Sparse (11 - 36 pop/Km^2)	50	10	North Eastern Province, Turkana, Samburu, Kajiado, Tana
Semi-agrarian/ semi-urban	Medium density (37 – 39 pop/Km^2)	100	20	Eastern Province (except Moyale and Isiolo) and Coast Province (except Tana River)
Agrarian/rural	Dense (40 – 53 pop/Km^2)	200	40	North and South Rift Valley
Agrarian/urban	High density (54 – 4576 pop/Km^2)	500	100	Central, Nairobi, Western and Nyanza Provinces

Recruitment and training of CHWs

CHW recruitment by community members (including CHEWs) is conducted in *barazas* (community meetings) that are chaired by the assistant chief (administrative leader) in each administrative sub-location that consists of various villages. The criteria for CHW recruitment are as follows:

- permanent resident in the community, therefore available to provide sustained information and improved access to FP commodities;
- possess leadership qualities;
- mature and responsible individual who is a role model to the community (e.g. spacing of children, aware of water, sanitation and hygiene);
- respected member of the community;
- self-supporting, i.e. involved in an economic activity;
- willing to provide voluntary services for the community; and
- literate (preferably completed secondary education).

Notably, the requirement that CHWs are permanent residents implies that the community does not select young people who are likely to get married and move or relocate to look for work elsewhere. Hence the majority (over 50%) of CHWs are in the 41-50 age bracket and close to 30% are in the 31-40 age bracket.[44] Given the cultural and religious norms in Kenya, and despite the training of CHWs on counseling the youth, community members in this age group may not be comfortable discussing their sexuality with mature members of the community who are likely to be acquainted with parents and older relatives. Despite the requirement of CHCs to have one member who is a young person, it is likely that it is cosmetic. This raises concerns given the population policy position to target 15-34 year olds with access to contraceptive information and services, and the "youth bulge" in Kenya's age structure, estimated at about 35% in the 2009 population census.[45]

One way to overcome this challenge is the youth-friendly centers in the community that have youth counselors. However, these are not universal across the country and it would be ideal if there was harmonization with the CHW program. For example, the MOH/GTZ CBD activities in Nyanza and Western province were extended to address adolescent and youth SRH needs, through a peer education approach that involved the training of youth counselors[46]. Although the number of active youths out of those trained declined over time, the youth counselor was able to reach a large number of youth with information and supply of condoms.

> *Our CBD agents have targets to reach the youth through community youth centers and women's groups.*
>
> — Implementing agency representative

Another socio-cultural concern is that more female CHWs are recruited, raising the question of active male involvement in FP. A key informant highlighted that the existing passive strategy for male involvement is the supply of condoms by CHWs.

Key informants noted that previous recruitment of CHEWs was from a pool of retired allied health professionals (e.g. enrolled community nurses and public health technicians) as defined by the Community Health Strategy (2006), but that this has recently changed and now non-specialized recruiting is happening "from all over", albeit with a defined level of education.

CHW training curriculum

Following the November 2010 Community Strategy Convention, a training curriculum for CHWs[47] was developed by the MoH in consultation with implementing partners, the Inter-Agency Coordinating Committee for Community Strategy and development partners in order to harmonize the standards for community health service delivery. The curriculum is delivered by trained CHEWs and should be reviewed annually by implementing agencies and evaluated after two or three years.

The integrated training curriculum which is supposed to be delivered over a six-week period is composed of two sections which must be completed in that sequence, amounting to 324 contact hours and 160 hours of practical experience. Section 1 has six basic modules and practical sessions in the field for one month, which are requirements prior to practice in the community; and section 2 has seven technical modules on specific health issues.

The FP module which is delivered over six hours, seeks to "equip CHWs with the basic knowledge on FP methods and counseling skills so that they can provide selected FP methods and make timely referrals for other FP methods." A key informant noted that despite the good intentions, CHWs start practicing after the completion of the basic modules and the delivery of the technical modules occurs in an ad hoc manner, depending on when partners with interests on specific topics, e.g. FP, have funds to support it.

Table 3. Integrated Training Curriculum for CHWs

#	Section 1: Basic modules	Section 2: Technical modules
1	Health and development in the community	Water, sanitation and hygiene
2	Community governance and leadership	Community nutrition
3	Communication, advocacy and mobilization	Integrated community case management
4	Best practices for health promotion and disease prevention	Maternal and newborn health
5	Basic health care and life saving skills	Family planning
6	Management and use of community information and disease surveillance	HIV/AIDS, tuberculosis (TB) and malaria
7		Non-communicable diseases

> *We now have a standard national CHW training manual with 6 basic modules and 7 technical areas. Basic training is compulsory for any community unit, but the technical modules are an add-on depending on the [geographical] area of operation.*
>
> — Implementing agency representative

Box 2. Issues covered in the FP module

- Healthy timing and spacing of pregnancies for women of reproductive age, the youth, people living with HIV/AIDS and men
- Basic counseling on FP including effectiveness, advantages and expected side effects of FP methods
- Myths, misinformation and rumors of FP use
- Contraceptive options for HIV+ clients
- Requisition for FP commodities
- Provision of FP methods in the community

Notably CHCs also undergo standardized training to build their understanding of the Community Health Strategy and the link between health and development, roles and responsibilities of CHWs, CHEWs and CHCs and also has modules to build their leadership skills including governance, personnel management, resource mobilization, monitoring and evaluation (M&E), etc.[48] However, a key informant highlighted that there are no policy documents to guide the operations of CHCs.

Service provision by CHWs

It is important to note that CHWs provide a range of services, including the provision of FP commodities[b], which are limited to combined oral contraceptives and condoms (see appendix IV for

[b] Services provided by CHWs in CUs: Water and sanitation hygiene; advise on maternal and child health; provision of FP commodities; growth monitoring for children under five years; deworming of children; provision of long-lasting insecticide-treated nets; management of minor illnesses (e.g. diarrhea, injuries, wounds, jiggers); provision of IEC materials; defaulter tracing (ART, TB and immunization); referrals to health facilities; first aid services.

CHW kit). CHEWs are responsible for referral of patients to the next level of health facility, using a referral tool. CHWs refer clients for FP methods that they do not provide, which include DMPA/injectable contraceptives (in areas where policy does not allow for provision), implants, IUCD, vasectomy and tubal ligation. The findings from a UNICEF/MoH 2010 evaluation of FP services in community service provision in 21 districts (3387 respondents in a household survey) that compared areas with community units and those without[49] found that Kenya's CHW program is successful in promoting and improving access to FP services, and therefore will ultimately increase FP utilization. Notably, the assessment was conducted a mere six months after implementation of the *Community Health Strategy (2006)* had begun, which may explain the small percentage differences (see table 4). In addition, the authors do not indicate the significance level to help readers interpret the findings, but do posit that only utilization of FP services was insignificant, implying that the significance level was above p = 0.05. That said, it is important to note that given the relatively high baseline values and short implementation time, any performance indicator increments are noteworthy.

Table 4. Assessment of Knowledge, Uptake and Utilization of FP Methods

Indicator	Intervention site* (%)	Comparison site* (%)	Difference (%)	Significance test
Knowledge of at least one FP method	86.6	84.2	2.4	χ^2 = 3.223, df =1, p= 0.073 (Borderline significant)
Access to FP services	87.2	86.1	1.1	Borderline significant
Utilization of FP	47.4	47.2	0.2	χ^2= 0.006, df =1, p= 0.940 (Not significant)

* The intervention site refers to well established CUs with the Community Health Strategy implemented for a period of six months or more; while the comparison site refers to sub locations where the CU has not been established within the same district

A CHW standard referral form is used to increase the effectiveness of referrals. A MoH assessment in 2012[50] recommended establishment of a community desk at the health facility to manage referrals and to strengthen community and health facility linkages.

Community health data collection and monitoring

CHEWs set service provision targets with CHWs based on community needs. Data collection tools that compose the Community Health Information System and their characteristics are listed in table 5.

Notably, FP-related information dissipates up the reporting chain. The CHEW summary (form MOH515) only contains stock-out information of FP methods, whilst the CHU chalkboard information (form MOH516) does not include any FP-related information for community discussion and action. This implies that FP is not on the agenda of community meetings, therefore a missing opportunity to promote FP in the community.

Table 5. Types of Data Collection Tools by CHWs and Frequency of Submission to CHEWs

Data collection tool	Type of data collected	Respon-sibility	Purpose	FP indicators	Frequency of submission / To whom
MOH513	Household register	CHW	To measure the actual CHW's outputs and outcomes as a result of household visitations	FP method used by women of reproductive age	Biannual / CHEW
MOH514	Service delivery log book	CHW	To measure the actual CHW's effort during household visitations	Number of women (15-49years) provided with FP commodities	Monthly / CHEW
MOH515	CHEW Summary of Community Unit*	CHEW	Community Health Unit (CHU) Outputs	Stock-outs of more than 7 days for COCs and condoms	Monthly / Sub-county Health Management Team to be entered into the Health Information System (DHIS2)
MOH516	Community health information	CHEW	Translation of community health data collected to trigger community action	None	Monthly / Community Health Information System (Chalkboard) and copied to CHC

* Collated using data from the community service log book, treatment register and supply work sheet (at the end of every month) and from the household register (after six months).

The M&E framework that was launched in April 2013 [c] to coordinate and harmonize the implementation of the Community Health Strategy was undergoing major revisions during the time of the study. This framework will have defined performance indicators, objectives, frequency of data collection, etc. A National Communications Strategy for Community Health Services (2012-2017) provides a framework for advocacy, mobilization and coordination of communication interventions (behavior change communication), capacity strengthening in management for health communication, knowledge management, and awareness-raising of the Community Health Strategy.

[c] Ministry of Public Health and Sanitation, Division of Community Health Services. Monitoring and Evaluation Plan for Community Health Strategy (2013-2017) Version 1. April 2013

At the time of this study quality of care standards for training and supervising/mentoring CHWs were in preparation for launch by April 2014.

> *Managing quality and safety standards of services provided by CHWs worker will appease the [clinical] professional associations.*
>
> — Implementing agency representative

Notably the Kenya Health Sector Strategic Plan (2013-2017) target is for the proportion of women of reproductive age receiving FP to increase from 45% to 80% by 2017.[51]

Remuneration/compensation of CHWs

The CHW program is based on the principles of volunteerism and this is made clear to community members during recruitment. That said, a key informant noted that after a few weeks of service, it is not unusual for CHWs to demand payment for their work. Notably, the responsibilities of CHWs have increased since inception of the program in the 1980s, where standardized data collection and reporting did not occur. Further, the labor laws of the Republic of Kenya have demanded that the term CHW is made redundant and the term Community Health Volunteers (CHVs) is used – MoH is in the process of changing its documentation to reflect this.

Non-monetary incentives for CHWs include bicycles, training workshops and certificates, exchange forums with other CHWs, etc. A 2010 policy change[52] introduced a payment by performance incentive for CHWs of KES 2,000 (about US$25) per month to strengthen Community Health Services by improving retention and performance on key health indicators. However, its implementation by the MoH is sporadic as there are no funds allocated to it by the Ministry of Finance; however, implementing partners such as APHIA*Plus* Zone 4 (Eastern and Central), JHPIEGO and Pathfinder International are implementing this policy. There is therefore need for harmonization of compensation amongst CHWs.

> *The Ministry of Health and the NGOs need to talk one language. We are still working in silos. … We need policy level solutions.*
>
> — Implementing agency representative

An annual summit for rewarding CHWs that is run by CUs has also been introduced. The MoH is developing performance indicators based on high impact interventions at the community level (not necessarily FP) to be used as bench marks for the awards.

Commodity security

The CHW kit is delivered to health facilities by the national specialized medical logistics provider, Kenya Medical Supplies Agency (KEMSA) (see appendix IV for the CHW kit contents). CHEWs collect these and distribute them to the CHWs that they are supervising. CHEWs have a buffer stock in the health facilities that is reserved for CBD. CHWs get their commodity supplies replenished by the CHEWs on a monthly basis during supervisory visits.

CHWs use reporting forms/tools to indicate the consumed stock and the balance stock at the end of the month. CHWs are allowed to make commodity orders through the CHEWs in-between the month if they run out of stock. To ensure commodity security, CHWs are trained on ordering in good time and filing their returns regularly. The biggest challenge faced by CHWs is commodity stock-outs mainly because of inaccurate ordering. In addition, CHWs collect their supplies from the nearest health facility during the monthly supervisory meetings. Given that most of the facilities are very far from the communities, CHWs may not attend the supervisory meetings and thus will not restock their supplies, resulting in stock-outs. Further, if there is a national stock-out of commodities, the CHW program is also affected, as they receive their commodities from the national supply chain. For example, the looming stock-out of condoms in 2014 will affect the CBD work.

Notably, the devolution of healthcare services including procurement and distribution of commodities is a potential challenge. The first challenge is the criteria that will be used by the national government to allocate the US$8.8 million budgetary allocation (2013-2014) for contraceptive procurement to the 47 counties is yet unknown. The second challenge is whether county governments whose mandate is to prioritize expenditure of county funds will indeed budget for and procure FP commodities with funds allocated by central government for procurement of contraceptives, or if they will channel them to other priorities. According to a key informant, county governments are focused on infrastructure development "which can be immediately seen" as opposed to the benefits of FP on development, which are long term and would be evident way in the future. As such, the commodity security of the CHW program will differ from one county to another depending on the county leadership's political will and commitment to support the program.

To ensure commodity security several strategies may be implemented, including provision of bicycles to CHWs for easier movement within the community and to health facilities for supervisory meetings and training them on robust record keeping so that they are aware of the managing stocks according to consumption data. Use of mobile text messages to report logistics data has been found to reduce commodity stock out in Malawi.[53] This system, known as *cstock,* sends data to a central system in the district which uses the data to calculate the resupply stock required. Effective national level coordination and routine quantification is required so as to mobilize sufficient funds for timely procurement and distribution of commodities. Therefore, the CHW commodity requirements should be integrated into the national supply chain.

Coordination of the CHW program

An Inter-Agency Coordinating Committee for Community Strategy which consists of all implementing partners and is chaired by the MoH meets monthly to coordinate implementation of the CHW program and provides policy and strategic oversight. The committee appoints technical working groups (TWGs) as required. At the time of the assessment, a Community Health Standards TWG, Capacity Building TWG and Operational Research TWG are underway to support implementation of the Community Health Strategy. The CHW Kits TWG, Data Collection Tools TWG and Referral Guidelines TWG have been closed upon completion of their tasks. Notably, given the mandate of the CHSU to implement the FP Guidelines (2010), the Reproductive and Maternal Health Unit is a member of the Inter-Agency Coordinating Committee and the CHSU is a member of the TWGs appointed by the Reproductive and Maternal Health Unit. There is also reportedly good regional

coordination of the CHW program. However, the challenge is at the community level where various implementing partners deliver services in silos.

Implementation gaps

Despite the development of the Community Health Strategy in 2006, implementation is documented to have stalled until 2010,[54] although a MoH representative stated it was towards the end of 2008, implying it had not yet been scaled up. The FP component was also very weak and was hardly taught in the CHW training, leading to the revision of the FP module in 2012.

One of the delays has been the lack of implementation guidelines to guide service provision at the community level. In 1990, NCPD and the MoH's Division of Family Health developed draft policy guidelines for CBD programs relating to medical issues and a screening checklist, logistics and health information systems, job remuneration and support for CBD agents, geographical coverage, and the selection, training and supervision of CBD agents. However, they were never formally endorsed as government policy. A key informant, however, noted that the Nursing Council is currently leading the development of implementation guidelines. Further, the FP component in the CHW curriculum was weak and it was revised, with the support of implementing partners to incorporate it. Notably, training in FP is not strictly a requirement to practice as a CHW and therefore an "add on" as opposed to essential knowledge for provision of community-based services. The greatest challenge that was noted by key informants was the lack of financial resources to run the CHW program.

> *Financing the strategy is greatest challenge – GOK should allocate resources.*
>
> — Implementing partner representative

> *Government-driven program required more allocation to service providers.*
>
> — Government representative

Operations research to strengthen delivery of Community Health Services (CHS)

The Operations Research Unit within the CHSU defined a National Community Health Services research agenda (see appendix V) that is grouped into nine thematic areas. Ongoing research includes performance of CHEWs, costing of delivery of community health services in the four socio-economic regions that govern geographical coverage of CHS service delivery. Further, the Operations Research Unit coordinates community health services research that is undertaken by various research bodies and is charged with collating and disseminating findings.[55] All research findings, in tandem with advocacy, are expected to inform evidence-informed policy development and policy revision.

Japan International Cooperation Agency (JICA) embarked on the Project for Strengthening the Community Health Strategy in Kenya[56] in October 2011 to provide support in policy coordination, communication and social advocacy, M&E and operations research. So far, the project has provided technical and financial assistance in the revision of the CHS Communication Strategy, CHW training manuals and M&E plan.

Future plans and prospects for the sustainability of Kenya's CHW program

An assessment of best practices in CBD programs in SSA recognized that various models can succeed so long as they meet local needs.[57] The assessment also identified a set of best practices to maximize the performance of CBD agents and the program as a whole. This framework was used to perform a bird's eye view examination of Kenya's CHW program (table 6).

Table 6. Best Practices of CBD Programs

Strategies to improve agent performance	Observations of the Kenya CHW program
i. Recruitment requirements are in line with productivity of agents e.g. status in the community, literacy, agent use of FP	This is already in place, however, some requirements implicitly exclude younger people.
ii. Size and location of catchment area maximizes performance	The *Community Health Strategy (2006)* was revised to take population density into account.
iii. Setting of client visit is cost-effective (home visit vs. specified community location)	Kenya's model is active service delivery. Its cost-effectiveness, however, has not yet been established.
iv. On-the-job training vs. off-site training to cut costs; refresher trainings; use of a training algorithm; training focused on single target groups e.g. youth or single women	Training of CBD agents occurs off-site, using a generic training manual which is split into 2 components – basic module and technical module (includes FP). However, only the basic module is mandatory for CHWs.
v. Supervision of CBD agents including group supervision to cut costs and selective supervision with high-performing or low-performing agents	Supervision of CHWs is conducted by CHEWs; however, this study did not assess the on-the-ground realities.
Controlling costs and moving towards sustainability	**Observations of the Kenya CHW program**
i. Compensation mechanisms and program management: • Volunteers - low recurring costs but high turnover and increased need for training new agents • Salaried – low turnover, smaller staff, but higher recurrent costs • Stipend – lower turnover and recurrent costs, but requires good monitoring • Commission – strong incentives to produce, low recurring costs, but requires good monitoring	Volunteerism model with both monetary and non-monetary incentives. Monetary incentives, however, are *ad hoc*, and if any occur in areas where the CHW program is being run by implementing partners, resulting in low motivation of CHWs.
ii. Commercial models (direct sales of FP products)	FP commodities are provided free.
iii. Logistics/commodity security	CHW kits are supplied and replenished by CHEWs, however, product availability relies on the efficiency of the national supply chain management.
iv. Planning and M&E	The *Community Health Strategy* guides planning, however an M&E framework is underway.

The sustainability of Kenya's CHW program is uncertain given the increasing responsibilities conferred to the CHWs in terms of data reporting and supervision. Compensation, which affects motivation and consequent high attrition of CHWs, remains a thorn in the flesh for the CHW program.

> *No government will pay CHWs.*
>
> Implementing agency representative

A number of mechanisms to support the sustainability of the program are imminent. Due to the high expense of the performance incentive, the MoH is also looking to implement alternative compensation mechanisms such as (i) establishing income-generating CHW cooperatives that provide commodities at a fee and keep the profits, (ii) funding CUs by the Health Sector Service Fund, and (iii) having CHWs on the MoH payroll. However, the latter has no government commitment. The MoH is exploring obtaining financial support for training and employment of CHWs from the 1 Million CHW Initiative,[58] a United Nations-led campaign with endorsement from the African Union that is in response to the health worker crisis in SSA, particularly in rural areas, that calls for countries to have 1 million CHWs by 2015. According to a key informant, the policy change to allow DMPA administration in defined hard-to-reach areas in Kenya was supposed to be a short term measure to reduce the burden of nurses whilst there is targeted training and recruitment of nurses in these areas. However, this is not the case as yet.

Further, there is a move to institutionalize active community health service provision by establishing CHEWs as the lowest cadre of employed health workers in the health service, similar to the Health Extension Workers in Ethiopia who are supported by Community RH Agents and Malawi's Health Surveillance Agents who are supported by Community Based Delivery Agents. The "dual-cadre" model of task sharing teams that are composed of voluntary, non-clinically trained CHWs that are paired with a mid-level health professional (e.g. nurse or midwife) presents an opportunity for improved access to RH/FP services based on successes in maternal and newborn health[59]. The direct implications of this would be monetary compensation for community health service provision. A key informant noted that this has been approved by the Ministry of Public Service, but awaiting the circular to formalize the policy change. Active recruitment of more CHEWs will therefore necessitate a smaller pool of CHWs in the CUs, who will provide support to the CHEWs. The MoH target is to have 46,000 CHEWs, up from the current 2,100.

> *The future is bright for Kenya's CHW program. Capacity building of communities through training can change health indicators as they can manage their own health.*
>
> – Government representative

A notable challenge by a number of key informants is the new dispensation with devolution of resource allocation and implementation decisions regarding health to county governments. Buy-in from county governments on the benefits of community health services is therefore critical for it sustainability. A national coalition of partners was formed in 2013 to synchronize advocacy on FP in Kenya and enable county level prioritization of FP.

Devolution has slowed things down.

— Government representative

In addition to the aforementioned governance changes, a new director of the Community Health Strategy Unit was appointed in October 2013. It is hoped that the new leadership will capitalize on successes of the CHW program and steer forward a successful strategy to implement CHS to further improve FP and broader health indicators in the country.

Conclusion and Recommendations

Kenya's CHW program has indisputably revived since the repositioning of community health service delivery through the *2006 Community Health Strategy*. Seven years on since its development, however, full implementation of the policy has been delayed, particularly with regards to reinforcement of quality of care standards and a defined M&E framework to improve the program.

Community-based interventions and the value of CHWs in improving access to health services in the community resulting in improved health outcomes in Kenya is unprecedented.[60] Further, task shifting/sharing supply of FP methods to CHWs has been demonstrated to be a safe and effective and linked to increased uptake of FP.[61] Training, equipping and supporting CHWs is therefore regarded to be a high impact practice[d] in FP.[62] Kenya's FP program is driven by DMPA injectables, although the attribution to US government policy, which is a key funder of the FP program[63]or most popular choice when all options are available, is debatable given the inadequate supply of all FP methods and consequent stock-outs. That said, increased access to FP methods undoubtedly leads to greater choice and higher contraceptive use[64] and in 2008 MoH developed a strategy for Kenya's FP program to offer a balanced mix of short-acting, long-acting, and permanent methods.[65]

Increased access to DMPA injectables has been attributed to the successes of the FP programs of Ethiopia, Rwanda and Malawi.[66] Notably, in Kenya, the rationale behind acceptance of the administration of DMPA injectables by CHWs in hard-to-reach areas, a key consideration for the policy change, has not been fully realized as the strategy to train and recruit nurses in hard-to-reach areas and thereby render the task shifting to CHWs redundant remains unimplemented. Further, in addition to the concerns posed by nurses amidst validation of the safety and efficacy of CHW administration,[67] task shifting to CHWs and therefore increased national coverage in Kenya and other SSA countries was shadowed by the 2012 study that suggested women using progestogen-only injectable contraception may be at increased risk of HIV acquisition,[68] although a WHO expert panel recommended that the data associating HIV-1 risk with injectable contraceptive use are insufficient to mandate a policy change to restrict use of these methods, but women at risk of HIV-1 who use progestogen-only injectables should be counseled to consistently use condoms.[69] It is therefore imperative that the CHW training curriculum incorporates this as presently it explicitly addresses contraceptive options for people living with HIV/AIDS.

[d] High impact practices are promising or evidence-based practices that, when scaled-up and institutionalized, will maximize investments in a comprehensive FP strategy. See http://www.fphighimpactpractices.org/

A number of factors have been attributed to the success of Kenya's CHW program. The political will and commitment for community health service delivery is the foundation for this success. Placing health at the center of development and the reinforcement of community participation and empowering communities to take responsibility for their own health has been paramount to improving health outcomes at the community level, which ultimately translates to improved national health outcomes and contributes to attainment of development agenda targets. The association between increased contraceptive uptake and increased access of FP at the community level has already been achieved and a further boost in contraceptive uptake is anticipated to be evident in the imminent DHS, which will be the first one since the revival of CBD of FP in Kenya.

Granted, Kenya's CHW program has benefited from support from implementing and development partners. The reliance on external funding, although the government arguably provides CHEWs for supportive supervision of CHWs and allocates funds to purchase FP commodities (34% of the total requirement in the 2013/2014 fiscal year) raises serious concerns for its sustainability. Without any government commitment for funding the CHW program, the progression of its short lived success remains uncertain. Concerted efforts to attain local resource generation, mobilization and allocation mechanisms for the CHW program are therefore imperative. This is particularly necessary in the wake of the devolved governance structure in Kenya. Notably, devolved governance, whilst regarded as an impending challenge, also presents an opportunity for innovative implementation to yield maximum benefits to communities.

Other FP-specific service delivery challenges that need to be addressed to improve Kenya's CHW program include youth access and male involvement.

Recommendations

Based on this assessment, the following recommendations are made to the MoH:

1. Strengthen **policies, guidelines and protocols** to support implementation of the Community Health Strategy at community level and its evaluation, with inclusion of all key stakeholders, including clinical professional associations.

2. Spearhead together with relevant government agencies and implementing partners, **top level and county level evidence-based advocacy** for support of implementation of the Community Health Strategy.
    i. Harmonize county level advocacy efforts for the population policy with the National Council for Population and Development to support resource allocation to the FP program by demonstrating the link centrality of FP to reduction of maternal deaths and development.
    ii. Demonstrate the service delivery gaps being filled by CHW program and the economic benefits of the CHW program to the Ministry of Finance and county level leadership and health officers.
    iii. Develop and deliver induction trainings to the county level leadership and administration (County Health Management teams, etc.) on the Community Health Strategy and their role in its implementation.

3. Strengthen **community participation and FP acceptability** by demand creation campaigns and proactively engaging men and the youth in CHW provision of FP information and methods.

4. Strengthen **training and supervision** of CHWs.
   i. Enforce regular updating of the CHW curriculum and job aids based on research evidence and M&E findings. For instance, update the FP module to include counseling for barrier methods for people at risk of contracting HIV-1 who want to use progestogen-only injectable contraceptives.
   ii. Enforce refresher trainings of CHWs, CHEWs and CHCs and their trainers.
   iii. Enforce mentoring and supportive supervision of CHWs by CHEWs and explore meaningful incentives to improve quality of care and effectiveness of referral to health facilities.

5. Prioritize resource allocation **to operations research and M&E** to improve financial, human and technical capacity of the CHW program.
   i. Conduct a cost-effective analysis of CHS provision to advocate to Ministry of Finance.
   ii. Assess quality and safety of CHW service provision to advocate to Nursing Council and other key stakeholders.
   iii. Enforce quality assurance of documentation to support M&E of the program

6. Strengthen **community supply chain management** to ensure FP commodity security of authorized FP methods.
   i. Ensure effective national level forecasting, quantification and coordination.
   ii. Explore the use of technology to manage stock levels and make requisitions at the community level, e.g. use of mobile phones (mHealth).

7. Decisively address **motivation and retention of CHWs** to address sustainability of program.
   i. Establish monetary remuneration of CHWs to reflect their increased scope of practice.
   ii. Establish income generating activities through public-private-partnerships, e.g. social marketing.
   iii. Establish national networks for CHWs as platforms for knowledge sharing and problem solving

8. Embrace **knowledge transfer and exchange** from successful low- and middle-income countries to learn lessons and contextualize them to improve the CHW program and ensure its sustainability.

Appendix I. Mapping of the CHW Program in Kenya

Agency	Location	Sector	Year started	Year ended	CBD status	Direct clinic link	Services offered	Coverage
MOH/GTZ	Rural	Public	1991	Ongoing	Volunteer/ incentives	Yes	SRH, FP distribution and health information	2 provinces 6 districts
Pathfinder supported	Rural and Urban	NGO	2003	Ongoing	Volunteer/ incentives	Yes	RH/FP, HIV/AIDS	3 provinces; 4 districts
FPAK	Rural	NGO/MOH	2010	Ongoing	Volunteer/ incentives	Yes	FP distribution and health information	I province; Siaya County
MOH and Population Council	Rural	Public	2005	Ongoing	Fee for service	Yes	EMOC, newborn care and FP	I province; 4 districts: Mount Elgon, Bungoma, Lugari and Butere Mumias
MOH	Rural	Public	2009	Ongoing	Volunteer/ incentives	Yes	FP-Condoms, pills, injectables	1 province; 1 district
Family Life promotion and Services (FLPS) Project	Urban	NGO	1988	Stopped	Part-time/ allowance	Yes	FP-Condoms, pills, health information	2 urban centers- Nairobi and Kisumu
Nairobi City Council FP project	Urban	Public	1987	Stopped	Full-time/ salaried	Yes	FP-Condoms, pills, health information	8 urban divisions in Nairobi
Nairobi City Council services	Urban	Public	1989	Ongoing	Volunteer/ incentives	Yes	FP-Condoms, pills, health information	7 urban slums in Nairobi
MYWO	Rural	NGO	1983	Shifted to HIV/AIDS in mid 90s	Part-time/ allowance	No	FP-Condoms, pills, health information	5 provinces, 10 districts; Muranga, Kakamega, Kirinyaga, South Nyanza, Bungoma, Machakos, Kitui, Embu, Meru and Isiolo

FPAK	Rural	NGO	1982	Stopped	Part-time/ allowances	Yes	FP-Condoms, pills, health information	7 provinces 18 districts
CHAK	Rural	Church	1989	Shifted to HIV/AIDS in mid 90s	Part-time/ allowances	No	FP- pills, health information	5 provinces 9 districts
Chogoria Mission Hospital Community-Based Services	Rural	Church	1983	Ongoing	Volunteer/ incentives	Yes	Distribution of condoms, foam, jelly and contraceptive pills, MNCH, provision of information on health related topics	1 province, 1 district; Tharaka

This table is an update of Chege and Askew, 1997.[70]

Appendix II. Interview Guide

African Institute for Development Policy
Bridging Development Research, Policy and Practice

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INTERVIEW GUIDE

Policy and programmatic evolution of the Community-Based Distribution of family planning in Kenya and prospects for its sustainability

PERSONAL INFORMATION

Name of Interviewee	Date of Interview _____/ ____ /2013
Position of Interviewee	Name of Interviewer
Interviewee's Institution	Interviewee's ID No.

BACKGROUND AND CONSENT TO INTERVIEW

Thank you so much for meeting with me today. My name is **[Name]**. The African Institute for Development Policy (AFIDEP), based in Nairobi, Kenya is conducting a **comprehensive and systematic assessment of Kenya's community-based distribution (CBD)[e] of family planning (FP) program**, in order to better understand and document the characteristics and evolution of the program in order to assess how its growth and/or decline is linked to overall modern contraceptive use trends in Kenya.

[e] CBD is a non-clinical strategy through which community members (with or without remuneration) provide family planning services and information at convenient locations in villages, markets and at homes.

As part of this study, we are talking to a range of stakeholders including policy makers, program managers, donors and civil society organizations in order to get insights on the progress of the CBD program since 2000, key challenges, and the overall sustainability of the program, and obtain recommendations on what should be done to improve policy and program responses to these challenges. In particular, we would like to understand the prevailing policy and program environment, the structure of the CBD program and the efforts being advocated to close any gaps. The information obtained will be used to make recommendations to reinforce FP uptake in Kenya.

The research team has requested an interview with you because of the important role that your organization plays in FP in Kenya and we believe your insights will be valuable in understanding these issues and what this country should do to address policy and program bottlenecks. I have some guiding questions, but I would appreciate it if you feel free to talk about anything you think is important for us to know.

The survey will take about an hour. Please, note that participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. You may also stop the survey at any time. However, we hope that you will participate in this survey as your views are important.

Do you want to ask me anything about the survey?

Will you participate in this survey? **YES** **NO**

I will be taking notes as we talk to be sure I don't miss anything. Is that alright? **YES** **NO**

I would also like to ask for your permission to record the interview. The purpose of recoding is to enable me produce an accurate and detailed transcript of our conversation since it is not possible for me to write everything that you will say during the interview. We will ONLY use the audio recording to transcribe the interview and we will delete the audio file soon after the transcription.

Is it ok for me to record the interview? **YES** **NO**

IF YES – Go ahead to record the Interview

IF NO – Try to explain again the purpose, and if the answer is still NO, then continue with the interview, recording as much detail as possible and type-up the full transcript of the interview within 24 hours.

Signature of interviewee: _____

Date:_____

Note: Questions to be targeted to key stakeholder – policy maker, program implementer or donor. Skip inappropriate questions

Context setting on prioritization of CBD policies and programming

1. What role has your organization played in CBD programming in Kenya? Since when?
2. What policies have governed CBD programs in Kenya since the inception of its family planning program? What triggered the policy changes?
3. How did the policy changes occur?
   Probe:
   - Describe the process
   - Did advocacy play a role in triggering/supporting the policy change?
   - If yes, who were the key players? What were the 'policy asks'?
4. What were the challenges experienced in making the policy changes?
   Probe:
   - Which organizations/professionals opposed the policy changes?
5. What has prevented the endorsement of national guidelines to standardize service provision in Kenya's CBD program?
6. Is there any legislation or legislation gap that affects CBD programming? What should be done to address this?

CBD Program Implementation

The following set of questions is to help us characterize CBD programs in Kenya:

1. What are the characteristics/models of CBD programs in Kenya in the following categories?
   i. Models/classification – please provide examples
      - *Type I:* Fixed delivery points such as village health posts, satellite clinics, kiosks (Active clients vs. passive CBD program)
      - *Type II:* Doorstop services provided by paid workers and volunteers (Passive clients vs active CBD program)
      - *Type III:* Comprehensive programs that involve combinations of Type I and Type II approaches, usually where demand for family planning is fragile and new.
   ii. Geographical coverage
      - How are catchment areas determined?
      - What's the rural/urban coverage?
      - Are areas with low contraceptive prevalence rates given extra attention and support?
      - How many individuals/families/households does one CBD agent reach?
   iii. Recruitment
      - What are the criteria for CBD agent selection?
      - Are personal characteristics taken into account when recruiting new CBDS agents (e.g. sex, age, marital status, religion, etc.)? What's the male/female proportion?

- Are there CBD agents targeted to certain community members e.g. the youth?
- Is the community involved in selection of the CBD agents?
-

iv. Please describe the range of information and services provided by CBD agents, including FP method mix
   - Oral contraceptives, condoms, spermicide, standard days method (SDM), lactation amenorrhea method (LAM), DMPA injectable, other?
   - Counseling and referral for long-acting and permanent methods e.g. vasectomy, tubal ligation, implants, IUDs
   - Are CBD agents only allowed to resupply or can they provide FP methods to new clients or switch methods to existing clients?

v. Referral system
   - Are there national guidelines to inform a systematic referral mechanism from CBD agents to health facilities, and vice versa?
   - What are the referral requirements for clients from CBD agents to health facilities?

vi. Supervision
   - What are the supervision channels and reporting mechanisms for CBD agents?
   - How many CBD agents does one supervisor manage/supervise?
   - How frequent are supervisory meetings?

vii. Reporting
   - What are the formal data collection mechanisms? Is there a standardized recording and reporting system?
   - How often does data collection occur-real time (supported by phone), weekly, monthly, during supervisory visits?
   - What indicators are reported?

2. Are there community mobilization/publicity events to inform the public about CBD agents and their role?
3. Which organizations are running CBD programs in conjunction with the government's program? Has there been a formal mapping exercise?
4. What are the characteristics/models of these non-governmental run CBD Programs?
5. How are the different CBD programs coordinated? Is there a technical working group?
   Probe:
   - How is duplication of efforts avoided?
6. What is the monitoring and evaluation mechanism in place to assess/ensure quality of care?
   Probe:
   - What are the defined performance and monitoring indicators to assess the CBD program? (E.g. new acceptors recruited, revisits attended/continuing users, CYPs generated by FP referrals to health facilities)
   - How does GoK/Division of Reproductive Health ensure standardization of quality of care provided by public and non-public service providers (CSOs, FBOs, etc)? E.g. observations of client-provider interactions and exit interviews with clients,

7. What are the prospects of the sustainability of Kenya's national CBD program? What measures need to be taken to ensure this? Any plans for national scale up?
8. How are these efforts working? What are the main challenges being experienced in CBD of FP in Kenya?
9. What needs to be improved or changed?
10. What are the chances that the CBD of FP will help Kenya achieve its FP near term goals and targets? (Contraceptive Prevalence Rate of 56% by 2015)
11. How is Kenya's FP program taking advantage of global initiatives, e.g. the FP2020 initiative? What should be done to optimize benefits from these global initiatives in Kenya?

Training/curriculum of CBD agents

1. Are all CBD trainings standardized by the National CBD Training Curriculum (including those trained by non-public service providers)? Is it regularly updated?
2. What are the minimal education requirements for CBD agents?
3. How is the training conducted (Methods: lecture, field work in the community, etc.)
4. How long is the training?
5. Are CBD agents trained in other reproductive health issues and encouraged to act as sources of information for other community members, e.g. the youth? (requires training in provision of youth-friendly services)
6. Are CBD agents trained about integration of FP with other SRH issues such as HIV?
7. What other primary health care issues do CBD agents receive training in? E.g. diarrhea, malaria, breast feeding, STIs, malnutrition, etc.
8. Are there refresher trainings to reinforce existing skills or introduce new skills? If yes, how frequent are they?
9. Are CBDs provided with the GoK/Division of Reproductive Health job aids/checklists?

Remuneration/compensation of CBD agents

1. What are the remuneration arrangements or non-monetary compensation/incentives for CBD agents?What is the source of remuneration (Government, NGO, Community)?
   Probe:
   - Distinguish between public vs. non-public CBD agents
   - How will this impact the sustainability of the CBD program and how can it be addressed?
2. Is there a mechanism to assess job satisfaction?

Commodity security

1. How is supply and monitoring of the CBD agents stock carried out and supervised?
2. Are there any issues and challenges experienced in the national CBD program that are related to commodity security? If so, how can they be addressed?

Concluding remarks

1. If there are two or three things you can name that have really made a difference in Kenya's CBD program, that others can learn from, what are they?
   - Prompt: it can be a policy, a process, an event, an FP champion, etc.
2. What would you say is the number one challenge that needs to be addressed to improve Kenya's CBD program in terms of improving access to FP and other SRH services in the country? What should be done to address it?
3. What are the key advocacy messages or 'policy asks' that are currently directed to GoK/Division of Reproductive Health for Kenya's CBD program?
4. Is there anything else I may not have covered that you would like to add?

Thank you very much for your time

Appendix III. Key Informants

1	Ministry of Health, Division of Reproductive Health (DRH) now RMHU	Dr. Bartilol Kigen
2	Ministry of Health, Community Health Services (CHS) now CHSU	Dr. James Mwitari
3	National Council for Population and Development (NCPD), Ministry of State for Planning and Devolution	Mr. Karugu Ngatia / Ms. Catherine
4	Population Council	Dr. Ian Askew / Mr. Wilson Liambila
5	FHI 360	Dr. Marsden Solomon / Ms. Alice Olawo
6	JHPIEGO/Advance Family Planning (AFP)	Ms. Rose Maina
7	Pathfinder International	Ms. Pamela Onduso
8	Family Health Options Kenya (FHOK)	Dr.Richard Muraga/ Mr. Amos

Appendix IV. CHW Kit Contents

Category	SNo.	Item Description	Unit of Measure	Unit of Issue	Quantity Required	Unit Cost	Total Cost	Replenishment Plan
Medicines	1	Albendazole 400mg	Tablet	1000	1	1295	1295	Quarterly
	2	Paracetamol 500mg	Tablet	1000	6	266	1596	Quarterly
	3	Tetracycline Eye Ointment 1%	Tube	5g	50	15	750	Quarterly
	4	Low Osmolarity Oral Rehydration Salts (ORS) 20.5g/L	Sachet	1	200	2.6	520	Quarterly
	5	Zinc Sulphate 20mg	Tablet	100	3	250	750	Quarterly
	6	Combined Oral Contraceptives	Tablet	Cycle	1000	21.3	21300	Quarterly
	7	Vitamin A 100,000 IU	Capsule	100	10	696	6960	Quarterly
	8	Vitamin A 200,000 IU	Capsule	100	10	696	6960	Quarterly
	9	Povidone Iodine Solution	Bottle	1 Litre	3	160	480	Quarterly
Equipment	10	Salter Scale	No.	1	1	14529	14529	Once
	11	Colour Coded Salter Scale	No.	1	1	780	780	Once
	12	Digital Thermometer	No.	1	1	150	150	Once
	13	Timer	No.	1	1	390	390	Once
	14	MUAC Tape	No.	50	10	600	6000	Once
Others	15	First aid box (spirit, disposable gloves	No.	1	1	1000	1000	PRN

Category	SNo.	Item Description	Unit of Measure	Unit of Issue	Quantity Required	Unit Cost	Total Cost	Replenishment Plan
		cotton, wool, strapping, crepe bandage)						
	16	Chlorine / flocculant (coagulant and disinfectant) – for turbid water	Sachet	1000	10	5000	50000	Quarterly
	17	Chlorine – clear water	Tablet	7000	2	14000	28000	Quarterly
	18	Lavibond Comparator (For measuring chlorine level in drinking water)	No.	1	1	40000	40000	Once
	19	DPD Tablets (used with Lavibond Comparator)	Tablet	10	100	60	6000	Quarterly
	20	IEC materials	No.	No.			1000	PRN
	21	Commodity Register	No.	No.	1	600	600	PRN
	22	Male condoms	No.	100	10	230	2300	Quarterly
	23	Medical Dispensing Envelopes	Pack	10 x 1000	1	5285	5285	Yearly
Total cost (KES)								196,645.00
Total cost – consumables (KES)								**126,911.00**
Total cost - equipments / non consumables (KES)								69,734.00

Source: Ministry of Public Health and Sanitation, Office of the Permanent Secretary. Circular on Community Health Strategy Policy Changes, 15th January 2013. Ref: MOPHS/ADM/2/30 Vol.I

Appendix V. National Community Health Services Research Agenda

1. What are the contextual issues/factors hindering the uptake of CHS?

2. What factors influence CHS linkages by structures (CHC, Link health facility committee DHMTs) and service delivery and social reciprocity? How can these linkages be made more effective taking in different contexts?

3. What factors enhance sustainability of CHS in various settings including urban and other highly migratory communities? What are the essential considerations in exit strategy and mechanisms by partners involved in CHS?

4. With respect to human resource team to ensure performance, what are the ideal:
    a. Characteristics and skills mix of CHW?
    b. Characteristics and skills mix of CHEWs?
    c. Mechanisms for motivation and retention of CHWs and CHEWs?
    d. What are the desirable workload and tasks and logistical support necessary, and how can they be sustained?
    e. Training and practice regulations to ensure adequacy and compliance?

5. What is a workable framework for collecting relevant, quality and reliable community data for use at community and other levels, and regularly feeding into planning and policy cycle?

6. What is the cost-effectiveness of the CHS, and its different components, arrangements and packages, based on cost maximization, and cost-effectiveness analyses? To what extent does the CHS implementation contribute to reduction of household cost of illness?

7. What are the sources, model/framework/approaches, mechanisms of sustainable financing of the CHS? How can the financing of CUs be synchronized with Health Sector Service Fund (HSSF), Facility Improvement Fund (FIF) and community based financing schemes?

8. What factors determine local scale up (with District) of CHS in different context and counties? To what extent has the CHS improved the delivery of KEPH by cohort at level 1 including NCDs and high impact intervention?

Source: Ministry of Health, Division of Community Health Services.

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