Access to Quality Family Planning Services at the Community level through Family Planning Community-Based Distributors-Kilifi County

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Background and Framing

Kenya is among the countries facing challenges in reducing maternal, neonatal, and child morbidity and mortality in sub-Saharan Africa. The country has made significant progress in reducing maternal mortality from 2000 to 2017 by 51.6% from 708 to 342 deaths per 100,000 live births, translating into an annual reduction of 2.86%. However, the reduction is below the substantive 6.4% yearly reduction rate recommended in achieving the Sustainable Development Goals (SDGs) and has marked regional disparities. The KDHS 2014 survey highlighted Kilifi as one of the 15 high-priority RMNCAH counties, contributing 98% of the total burden of maternal death in Kenya. The county recorded a Maternal Mortality Ratio (MMR) of 250/100,000 compared to the national MMR of 362/100,000[1].

Family planning improves child survival and reduces maternal deaths. Family planning programming over the years has adopted convenient, non-clinical community-based service efforts to improve the acceptability and efficacy of family planning programs. Non-clinical access to contraceptives can improve the quality, acceptability, and impact of family planning programs. The expanded non-clinical distribution of contraceptive choices, in turn, has led to a proliferation of large-scale programs in non-clinical family planning service delivery throughout the world. Widespread commitment to expanding non-clinical family planning programs is based on assumptions about the efficacy and appropriateness of various operational strategies.

Contraceptive unmet need is relatively high globally and regionally because of both supply and demand barriers. Globally, FP2020 focuses on reaching at least 120 million new family planning users by 2030; this can only be achieved by bringing FP services closer to the service seekers through a community-based distribution approach. Kenya has one of the most remarkable diverse CBD programs and activities globally. In the 1980s, CBD initiatives proliferated with the National Council for Population and Development and financial support from the Kenya USAID Mission, Pathfinder International, and Family Health Options Kenya.

Afya Pwani, in collaboration with the Ministry of Health in Kilifi County, designed a multi-pronged CBD approach to expand contraceptive discussions and voluntary choices at the community level. The project recruited and trained chiefs, assistant Chiefs, religious leaders, teachers, youth leaders, community health volunteers, traditional birth attendants, male champions, motorbike riders, shop attendants, tailors, and salon owners as Family planning CBDs.

The CBD program was implemented through home visits (household sessions), outreach, community /cultural events (barazas), groups, and one-on-one sessions. All the traditional and non-traditional referral agents were mainstreamed into the health system for effective referrals and linkage. The CBDs distributed contraceptives (contraceptive pill refills, male and female condoms). They also referred clients to the health care providers who provided the other modes of contraception. Besides, they provided health education (such as family planning, reproductive health, and child) and referred clients for clinic-based services.

[1] National Bureau of Statistics-Kenya Demographic Health Survey 2014

Project approach

Afya Pwani was a 5-year USAID-funded project implemented from June 2016 to December 2020 across seven sub-counties in Kilifi county, Kenya. The consortium was led by Pathfinder International and consisted of Palladium International and Plan international. The project was implemented to improve and increase access and utilization of quality health services in Kenya through strengthened service delivery and institutional capacity of county health systems in the county.

The Expanded community-based distributors' approach- Community FP Network

Components of the CBD program

1. Community-Based Distributors

The project recruited and trained; community health volunteers, traditional birth attendants, peer educators, male champions, barbers shop owners, saloons, motorbike –"Boda Boda" riders, religious leaders, chiefs, and assistant chiefs, among others as CBDs. The chosen volunteers shared similar cultural orientations and backgrounds and could relate to societal, cultural norms, customs, and advocate for transformative empowerment change among community members. The traditional (CHVs) CBDs were drawn from an existing network of community health volunteers attached to a community Health unit. In contrast, the peer CBDs were both drawn from existing youth clubs, institutions, and community structures.

2. Community-Based Distribution Outlets

In collaboration with the county and community leadership, the project recruited well-known and respected outlet owners, e.g, saloon, shop, and motorbike riders. The outlet spaces were used as spots for family planning information sharing to eligible clients, commodity stores for other CBDs, and distribution points.'

The project adopted 3 approaches towards CBD

(i) Door to door community-based distribution

(ii) Outreach- FP service delivery through partnership and teams made of the CBD, community health extension worker (CHEWs), male champion, and health care workers from Link facility. While the CBD provided FP information and refilled contraceptive pills, and distributed condoms, the CHEWS provided Injectable contraception and the Health provider implants and attended to FP issues that the CBDs are not able to address e.g., information and counseling gaps

(iii) Depot system a non-traditional referral agent (, Motorbike riders "Boda Boda") trained to provide information on family planning and provide family planning commodities (Pill refills, male and female condoms as well as act as distribution agents to the CBDs.

3. A link Facility: Establishing linkages to build a strong relationship between the CBDs and the HCWs while expanding access to FP services at the facility level through effective referrals

To expand access, availability, and utilization of other family planning methods that are not within the CBD mandate and enhance effective referral, the project trained Healthcare workers on community-facility linkage and reporting. The training targeted community-Based Distribution programming, focusing on community and facility commodity management, community reporting, work planning, referrals management, supportive supervision, and linkages. The training also emphasized that the link facility is directly in charge of community health outcomes. The project further facilitated facility meetings to familiarize the facility service providers to CBDs and generation of a work plan together with the CHEW and CBDs and a discussion on the continuum of care from facility to the community and vice versa.

4. CBD reporting structure.

The project adopted cluster leadership where a CBD (Cluster leader) led other CBDs, eased coordination and feedback. The role of the CBD cluster lead included: i) review CBD monthly reports for completion and accuracy ii)Monthly report collection, compiling, and collation, ii)liaise with the facility in

charge of commodity management, iv) liaise with the SCRHC and SCCFP to sensitize the CBDs on emerging issues related to FP during their field visits and provide topical updates v)plan for future activities. The facility service providers' support and oversite helped to ensure learning was transferred and improved services. The close coordination and networking between the CBDs and the facility service providers improved community involvement and participation in improving maternal health outcomes and visibility of the facility and the service providers in the community.

5. Mobile Outreach Services

Community Health extension workers (CHEWs) who coordinated the CBDs activities were trained and certified by the county to provide implants and injectable contraceptives methods to under-served and hard-to-reach groups in locations where the unmet need was high. Together with the CBDs, the team increased access through door-to-door FP service delivery with the supervisory role of the Nurse in charge, who ensured adherence to standards. This element improved the method mix at the community level.

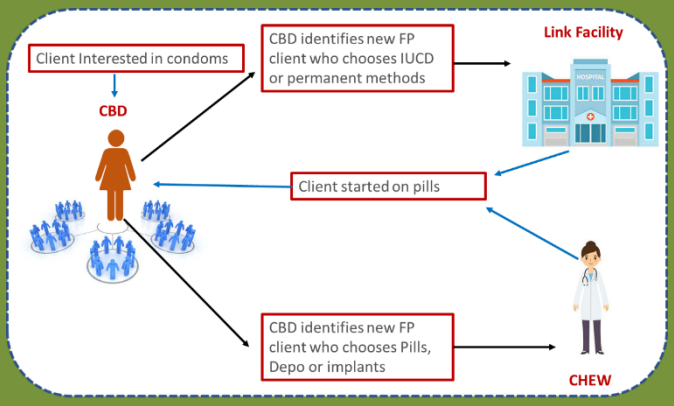
Steps in implementation of CBD

1. **County engagement and stakeholder's involvement**: The project engaged the county on the CBD programming, developed structures on CBD-programming implementation, and shared the CBD-programming structures in the Technical Working Groups. The project further networked with partners who were implementing the CBD-program in different capacities and merged for smooth CBD programming and higher yields.
2. **Community involvement:** Sustainability is critical in CBD programming; the program involved a pretty several community influencers chiefs, assistant chiefs, male champions, youth leaders, religious leaders, traditional birth attendants, and legislators. The legislators further engaged their officers to continue engaging the community through funerals, fundraising meetings, "*harambees*," and development programs in the constituencies. The influencers were trained as CBDs and given job aids to aid in messaging at the community level. The project further engaged community members through dialogues, outreaches, edutainment events, cultural events; the aim was to flood the community members with FP information and discuss them.

3. **Selection of CBD**: The project adopted a multi-pronged approach to recruit CBDs and break the belief that only traditional (CHVs) could reach community members with health information and service and refer. The project recruited; Community Health Volunteers, Traditional Birth Attendants, Peer educators, Kaya elders, male champions, Barbers, Shop owners, Salonists, Boda Boda riders, religious leaders, *Utawala na Afya (*Chiefs & assistant Chiefs), among others. The CBDs were then distributed in the 7 sub-counties, with Magarini having the high number of CBDS to mitigate the deep-rooted socio-cultural issues that influenced the health-seeking behavior of the community and was a barrier to family planning utilization.

4. **Capacity building, tool development, and dissemination:** The project, in collaboration with the Ministry of Health Kilifi county, conducted 5-day training on understanding a community and its systems, communication skills, family planning (overview, anatomy and physiology benefits, types, mode of action, limitations, side effects, myths, and misconception), CBD concept, Why CBD, linkages, commodity management, tools, reporting and effective referrals the essence was to i) empower the CBDs to educate, counsel and distribute commodities while improving the quality of community -based family planning ii) Establish linkages and build a strong relationship between facility in charges, community health extension workers and community-based distributors and iii) strengthen referral systems and supportive supervision to ensure program effectiveness and sustainability

5. **Training using the FP technical module, mentorship, post-training follow-up:** The project enhanced the competency of the CBDS on communication, counseling, commodity redistribution, danger signs while using pills, effective referral, education through listening approach, correct use and interpretation of job aids, and reporting writing. This was achieved through training using a high breed FP technical module on community strategy and family planning. Also, the project followed up the CBDs through mentorship conducted through sit-ins, dialogues, and household sessions at the community level



6. **Reporting tools:** The project supported the county to develop CBD reporting tools, Community Health Extension Worker (CHEW) Summary tool.

7. **Provision of job-aids:** For quality and consistency in FP messaging, The project developed and produced job aids (demonstration bags filled with all the methods), FP-flip charts to aid in the understanding of the Reproductive system, Badges, and branded t-shirts for ease of identification by community members.

8. **Strengthening referral and linkages:** The project trained Health Care workers on CBD concept, CBD programming, and its benefits in expanding the universal access to FP. The project linked CBDs to facilities and facilitated familiarization with the facility in charge. The project further Strengthened referral systems and supportive supervision to enhance program effectiveness and sustainability. The facility in-charges were to ease effective referrals by providing CBDs with referral forms, conducting continuous supportive supervision, and CBDs performance reviews

9. **Strengthening FP commodity security:** Commodity security is critical for effective CBD programming. The CBDs were trained on reporting, forecasting, and quantification of commodities. Through their enhanced knowledge of CBD programming, the facility in charge ordered buffer stock for CBDS by summarizing all the CBDs' average stock levels attached to the facility. However, perennial stock-outs were experienced due to delayed supply from KEMSA and strengthened monthly reporting and community data review while also refilling CBDs commodity stocks monthly.

10. **Service provision**: Integrated outreaches and household visits. The project adopted a CBD integrated approach, The CBDs were trained on Family planning, Maternal Health, Child Health, Nutrition, Gender, Adolescent Sexual Health, and Water Sanitation and Hygiene (WASH). During the household visits, outreaches, and forums, the CBDs passed integrated messaging and services

11. **Monitoring and evaluation**: coordination, supervision, performance review
In collaboration with the Ministry of Health, the project developed and improved reporting tools for the CBDs and a summary tool for the CHEW, and institutionalized community Health supportive supervision targeting CBDs. The Technical Assistance provided to the CHEWS by the project enabled them to develop strategies to improve effective referral systems for family planning services. This included household mapping of Women of Reproductive Age and Adolescents in Villages and their reproductive health/ family planning needs, exchange programs by CBDs to share experiences while learning. This was combined with new skill development such as commodity

Key achievements

- 1,070 community-based distributors were trained using MOH- community-based family planning curriculum
- Through an expanded community family planning discussion through CBDs programming, Kilifi County has made progressive advancements in increasing acceptance and utilization of FP services over time. Round 7 of the Performance Monitoring and Accountability 2020 (PMA2020) reported a 14%-point increase in the County mCPR from 33% (KDHS 2014) to 47% in 2020[2]. The survey also reported significant male support for family planning and growing female empowerment to make independent decisions about their reproductive health. The survey also indicated that 98% of the clients reported satisfaction with FP services they received, while 92% obtained their chosen choice method.
- Door to Door Family planning services by the CBDs contributed to Healthy timing and spacing of pregnancy discussions among the household members.

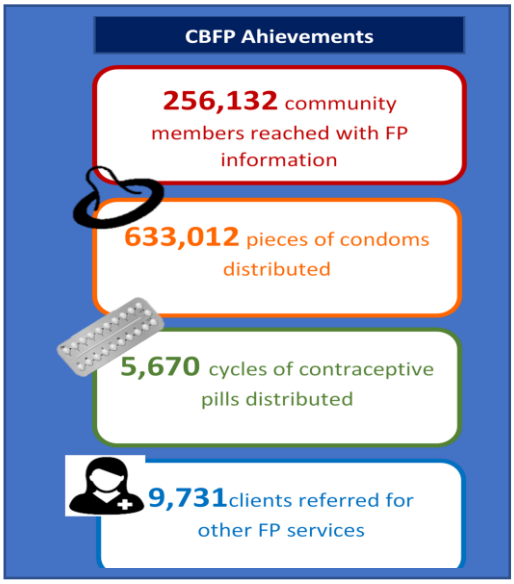
The work of the CBDs contributed to:

Community Based family planning offers:

- Pre conception counseling
- Bringing FP services closer to people
- Accessibility through CBDs and other cadres
- Increase access to and greater choice of methods
- Opportunity to introduce new methods

CBD implementation Strategies:

- Conducting family planning education sessions during home visits, one on one sit in sessions, group sessions, dialogues and at barazas.
- Door to Door community based family planning service delivery
- Outreach -FP service delivery with support from the facility service providers



Sustainability

To ensure the sustainability of community-based family planning (CBFP) approach through CBDs and outlet holders, several activities were built into the program:

- The CBDs were drawn from an already existing community Health strategy while the outlet CBDs were operating their businesses within the community.
- Communities, including facility service providers, administration officers (chiefs and Assistant chiefs), and facility Health committees, were involved in the CBD program, given roles, and were mobilized to participate in continuing CBD activities.
- The community-based distributors were Linked, and a relationship was established between community-based and facility-based programs to assist inconsistency.
- All the CBFP implementers were trained on community-based family planning programming
- Through CBD programming, the project entrenched an ownership culture among the CBDs by integrating CBFP messaging into their day-to-day activities, i.e., a CBD would cooperate with CBFP in community meetings addressing other issues.

[2] PMA Kenya ROUND 7 data set downloaded from https://www.pmadata.org/countries/kenya/kenya-indicators/pma2017kenya-round-7-indicators on 30/2/2021

Lessons Learned

The expanded Community Based Distribution program demonstrates evidence that when CBDs roles are strengthened and their capacity improved on new roles, they can successfully provide technical services such as counseling, commodity dispensing, documentation, commodity management, reporting, and deliver technical services e.g., implant insertion.

Teaming of CBDs, CHEWs, male champions, and Health care workers will further increase access to a broader contraceptive mix and further improve the quality of family planning services

Modifications to referrals and supervisory systems made tremendous contributions to quality assurance. This intervention illustrates that there is still a possibility of achieving good results in low-resource settings in social sectors such as health if certain conditions are satisfied. These conditions include financial but primarily technical support.

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