Reversing the Stall in Fertility Decline in Western Kenya: Evaluation Findings and Key Learnings

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

The PWK Project Consortium

- The African Population and Health Research Center (APHRC) coordinated all project activities.
- Marie Stopes Kenya (MSK) and Family Health Options Kenya (FHOK) implemented project activities in Busia and Siaya Counties, respectively.
- Great Lakes University of Kisumu (GLUK) conducted monitoring of project activities. During the expansion phase (2012-15), the project also coordinated with the other partners targeting specific sub-populations, including:
  - Center for the Study of Adolescence (CSA)
  - Forum for African Women Educationalists (FAWE)
  - Christian Health Association of Kenya (CHAK)

Faced with an alarmingly high population growth rate at independence in 1963, Kenya became an early leader among African countries in prioritizing family planning (FP) as an essential component of the country’s development strategy. Adopting its first national population policy and FP program in 1967, Kenya went on to have a strong and successful FP program in the 1980s and 90s, resulting in a dramatic decline in the fertility rate from 8.1 children per women in the 1970s to 4.7 by the 1990s. Community-based distribution (CBD) of contraceptives funded primarily by donors, is often credited for concurrent and equally dramatic increases in the modern contraceptive prevalence rate (CPR). However, as donor attention and funding shifted to HIV/AIDS, funds for FP declined, compromising gains in FP service provision and contraceptive use, and leading to a prolonged stall (and reversal in some areas) in fertility decline.

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

Against this backdrop, the PWK project was developed in 2009 as part of a larger national effort by the Kenyan government, donors, and NGOs to counter the stall in fertility decline in

**PWK PROJECT AT A GLANCE**

**Objective 1: Improve the supply of FP services**
- CHVs are recruited and trained to provide quality FP information, counseling, and short-acting methods
- Facility staff are trained to deliver LARC and reduce contraceptive stock-outs through improved commodity management (emergency buffer stocks were provided by the project)
- Mobile outreaches are organized to bring a full range of FP methods, including LAPM, closer to rural communities

**Objective 2: Generate demand for FP services**
- CHVs conduct household visits and community sensitization meetings, and distribute IEC materials
- CHVs provide referrals to facilities for reproductive health and FP services requiring medical intervention

**Objective 3: Creating an enabling environment for FP**
- Project activities are monitored and project achievements and lessons learned are disseminated
- PWK partners engage with county government officials and other partners in dialogue around FP issues
- Advocacy activities are conducted to promote county budget allocations to support FP and sustainability of project activities

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Kenya. The PWK project, initially launched as a three-year demonstration project (2009-2012), is a community-based FP initiative implemented in two large rural counties in western Kenya: Busia and Siaya. These counties were selected because of their high fertility rates and low CPR in 2009 and the absence of donor or other FP initiatives. From 2012-2015 project activities were intensified and scaled up in Busia and Siaya during the project’s expansion phase.

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

**KEY FINDINGS: IMPLEMENTATION**

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

Over 160 providers were trained on delivery of LARC methods, with some facility staff receiving training on commodity management. A 7-day training on provision of long-acting reversible contraception (LARC) was offered to facility in-charges and other providers identified by the county Reproductive Health Coordinator. Providers praised the comprehensiveness and quality of the training, believing it improved their ability to provide counseling on FP methods, while also allowing them to provide new contraceptive methods (implants and IUCDs). Facility staff also appreciated the commodity management training, though implementation of this training was more limited.

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

**KEY FINDINGS: SUPPLY OF FP SERVICES**

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

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

Mobile outreaches complemented CBD by expanding access to injectables and LAPM. Although more LAPM were provided in Busia, more males participated in outreaches in Siaya, resulting in high levels of condom distribution. In both counties, women appreciated the convenience of outreach locations and that services were provided free of charge. Outreaches served more than 24,000 FP clients.

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

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

The project increased the supply of short- and long-term methods. Across the various methods provided, the project generated over 139,000 couple years of protection (CYP) from 2013 to 2015, not including BTLs and vasectomies (Figure 1). Implants provided by the project accounted for over half of the project’s overall contribution to CYP. Despite the low conversion factor for condoms (120 condoms equals one CYP), the project distributed so many condoms that they account for the second largest share of the project’s contribution to CYP.

**KEY FINDINGS: KNOWLEDGE, ATTITUDES AND INTENTIONS**

CHVs shifted attitudes in support of FP. The project’s slogan, “jamii ndogo, jimuriti,” which conveyed the message that smaller families are easier to manage, seemed to be effective with beneficiaries. Most FGD participants understood that FP is about controlling rather than stopping childbearing, and that use of FP can have both health and economic benefits. Beneficiaries and CHVs noted that community members and leaders encourage women to seek out the CHV and use FP services, especially if they observe that a woman has been giving birth relatively frequently.

CHV efforts to engage youth have made youth more open to discussing FP topics. CHVs tailored their strategy to reach youth, leveraging youth group meetings and meeting them privately outside their homes. CHVs felt that, over time, it became easier and more
acceptable to talk to youth about reproductive health and FP, with parents becoming more open to CHVs talking to their children about these topics. CHVs commented that male youth have a high demand for condoms to prevent pregnancy and STIs.

CHVs had limited success in increasing male support for FP, but the project’s focus on the economic benefits of FP seemed to resonate with some men. Despite the project’s intention to target and engage men, women and CHVs complained that male support for FP is still low, with men fearing that female methods can cause permanent infertility, birth defects, and undesirable side effects. Outside of condom distribution, CHVs’ efforts to target men were not effective, with many CHVs, including male CHVs, preferring to circumvent unpleasant interactions with men during household visits. However, CHVs and beneficiaries noted that changing economic conditions and economic arguments for small families seem to be influencing some men’s attitudes toward FP.

KEY FINDINGS: USE OF FP SERVICES

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

The impressive increase in uptake of implants is one of the project’s notable successes, setting project counties apart from other areas and likely driving increases in CPR. Project activities contributed to a large increase in implant use over the course of the project. Implants accounted for almost all of the increase in modern CPR in the project counties during the project period, while use of other methods remained essentially flat (Figure 2). Project counties also had higher rates of implant use and lower rates of injectable use than surrounding counties in 2014, further supporting the project’s contribution to increases in CPR in the project areas (Figure 3).

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

KEY FINDINGS: IMPROVING THE POLICY ENVIRONMENT

Devolution presented risks and opportunities for FP in the PWK project counties. Under devolution, responsibility for health budgets was
transferred to newly-created counties, which were expected to finance government provision of FP services. Whereas Kenya had previously self-financed 50 percent of its FP commodity costs, in the first year that counties set their own budgets for health (2013), there were no budget allocations for commodity procurement in any counties. On the other hand, because devolution allows counties to determine their own priorities, the PWK project partners saw potential for the governments of Busia and Siaya Counties to become leaders in FP, setting an example for other counties to follow.

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

The project partners used a variety of mechanisms to disseminate evidence and learning. These include conference presentations, project reports posted on partners’ websites, and journal articles. However, advocacy and engagement with the national MoH, donors, and NGOs working on FP, was not a primary objective for this project—as a result, the project is not well known among national-level stakeholders.

KEY LEARNINGS

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

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

Increasing awareness and accessibility of LAPM, particularly implants, can have a dramatic impact on uptake. CHVs and facility staff counseled women on the full range of FP options available, and implants emerged as the...
most popular LAPM. The project utilized several vehicles to make LAPM services more accessible, including through referrals issued by CHVs, outreaches (particularly in Busia), and training of facility staff (especially in Siaya).

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

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

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

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

Monitoring systems need to be right-sized to the capacity of health workers collecting the data. The project’s ambitious monitoring system generated monthly data that were useful for program tracking and improvement, but CHVs and CHEWs noted that they spent a considerable amount of time on reporting—time that could have been used to provide services to communities. Reporting burden may also have discouraged facility staff from providing complete data.

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

KEY CONSIDERATIONS

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

Incorporating injectables into CBD could be a cost-effective approach to increasing CPR. The MoH already endorses CBD of injectables in underserved areas with high maternal mortality rates and low facility coverage. Although neither Busia nor Siaya County qualify as high-need areas using these criteria, allowing and enabling CHVs to provide one of the country’s most popular FP methods could spur further increases in routine contraceptive use. PKW partners could advocate for broader inclusion of injectables in CBD using evidence from other parts of Kenya and the PKW project.

County MoHs should consider different approaches to outreaches. The project’s demand-responsive approach to organizing outreaches was logistically challenging and may not be sustainable. However, an alternative approach to facility-based outreaches, such as one whereby MoH medical officers visit facilities on a regular schedule, may improve potential for sustainability and help ensure that members of rural communities have adequate access to the full range of contraceptive options.