African Population and Health Research Center

REVERSING THE STALL IN FERTILITY DECLINE IN WESTERN KENYA PROJECT REPORT

October 4, 2012 - November 30, 2015

AFRICAN POPULATION AND HEALTH RESEARCH CENTER

Promoting the well-being of Africans through policy-relevant research on population and health

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ACRONYMS

AFP	Advance Family Planning
AIDS	Acquired Immunodeficiency Disease Syndrome
APHRC	African Population and Health Research Center
ASRH	Adolescent Sexual and Reproductive Health
ASRHR	Adolescent Sexual and Reproductive Health and Rights
BTL	Bilateral Tubal Ligation
CBD	Community-Based Distribution
CBHI	Community-Based Health Information
CDE	County Director of Education
CHAK	Christian Health Association of Kenya
CHEW	Community Health Extension Worker
CHMT	County Health Management Team
CHV	Community Health Volunteer
CME	Continuing Medical Education
CPR	Contraceptive Prevalence Rate
CSA	Centre for the Study of Adolescence
CSE	Comprehensive Sexuality Education
CTU	Contraceptive Technology Update
CUs	Community Units
DCHS	Division of Community Health Services
DHMTs	District Health Management Team.
DHRIOs	District Health Records and Information Officer
DMPA	Depot Medroxyprogesterone Acetate
DRH	Division of Reproductive Health
FAWE	Forum for African Women Educationalists
FBO	Facility Based Outreach

FHOK	Family Health Options Kenya
FP	Family Planning
GLUK	Great Lakes University of Kisumu
HH	Household
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
ICFP	International Conference for Family Planning
IEC	Information Education and Communication
ITNs	Insecticide-Treated Nets
IUCD	Intrauterine Contraceptive Device
KDHS	Kenya Demographic Health Surveys
LAPM	Long Acting and Permanent Method
LARC	Long-Acting Reversible Contraception
M&E	Monitoring and Evaluation
MIS	Monitoring Information System
MoH	Ministry of Health
MSK	Marie Stopes Kenya
NGO	Non-Governmental Organization
NHIF	National Health Insurance Fund
PALS	Peer Advocates for Life Skills
PPD	Partners in Population and Development
PSI	Population Services International
PWK	Packard Western Kenya
RBA	Rights-Based Programming Approach
RH	Reproductive Health
RHE	Reproductive Health Education

SCHMTs	Sub-county Health Management Team
SMART	Specific, Measurable, Achievable, Realistic and Time-bound
SRH	Sexual Reproductive Health
TBD	To Be Determined
TFR	Total Fertility Rate
TICH	Tropical Institute of Community Health
ToTs	Training of Trainers
TSC	Teachers Service Commission
TWG	Technical Working Group
YFSs	Youth Friendly Services

LIST OF PARTNERS

African Population and Health Research Center (APHRC)

- Chimaraoke Izugbara
- Michael Mutua
- Sherine Adhiambo

Family Health Options Kenya (FHOK)

- Amos Simpano
- Ndenga Indagala
- Henry Anyona

Marie Stopes Kenya (MSK)

- Jacob Khaoya
- Jenipher Abonyo
- Julia Mayersohn

Center for the Study of Adolescence (CSA)

- Jacob Ochieng
- Maureen Ayimba

Forum for African Women Educationalists (FAWE)

- Teresa Otieno
- Isabel Naibei

Great Lakes University of Kisumu (GLUK)

- Gonzo Kizito Manyasi (Formerly)
- Richard Muga (Formerly)
- James Aringo GLUK

Christian Health Association of Kenya (CHAK)

- Jane Kishoyian

EXECUTIVE SUMMARY

The African Population and Health Research Center, in collaboration with its consortium partners Marie Stopes Kenya, Family Health Options Kenya, the Great Lakes University of Kisumu, Centre for the Study of Adolescence, Forum for African Women Educationalists and Christian Health Association of Kenya implemented the expansion phase of a community-based family planning project in two large counties in western Kenya: Busia and Siaya. In 2012, when the current phase of the project started, Busia and Siaya districts (later counties), had an estimated total population of 1.7 million (739,000 in Busia and 915,000 in Siaya).

The objective of the project was to increase routine use of modern contraceptive methods among women of reproductive age by eight percentage points specifically by: 1) influencing switching from short to long-term methods, 2) increasing modern contraceptive rate on young/low parity married women, 3) influencing men's attitudes towards FP uptake and reducing desired family size and 4) influencing fertility intentions among women and men.

This phase of the project was implemented over a three-year period between November 2012 and November 2015, with an additional three-month no-cost extension to February 2016. The project implementation strategies involved capacity-building through training of Community Health Volunteers, medical service providers, peer educators, religious leaders, and community members to deliver high quality family planning, reproductive health and information services at community, facility and outreach level. It also generated demand for family planning services through community sensitization meetings including/such as women's groups, youth groups, community ***barazas***[1], churches, schools, distribution of information education and communication materials and use of social media and theater groups.

In addition, the project conducted advocacy and policy engagement meetings with key stakeholders and policy-makers at the county and national level to influence diverse policies of interest to the project. This intervention aimed to drive the family planning agenda by pushing for consistent allocation of county resources to family planning and other reproductive health programs, and to encourage the two communities, through their opinion leaders, to shun sociocultural practices that barred women from accessing family planning/reproductive health services. In the long run, the project collected and documented key project achievements using an exclusive monitoring information system. These achievements, lessons and best practices were documented and disseminated at various county stakeholder meetings, and local and international conferences such as the Tropical Institute of Community Health and the International Conference on Family Planning.

A common project implementation model was developed as a guide towards implementing project activities to avoid duplication of efforts by different partners. In the model, overall coordination of partners' activities was done by African Population and Health Research Center

[1]Swahili word for a deliberation meeting held by a collective group of people. It is often used on public gatherings called by local public administrative officers such as chiefs to address their communities over emerging issues of administrative interest. Most of these meetings are sometimes mandatory and programs implementers find these meetings an easy access to majority of the community, while gaining support and buy-in from the public administration, as well as civic and local political leadership.

as the lead partner in charge of sub-contracting, general monitoring and supervision of partner activities and donor reporting on the project achievements. Delivery of services to all women and men of reproductive age in Busia and Siaya counties was done by Marie Stopes Kenya and Family Health Options Kenya, at the community level. This was through community-based distribution by the Community Health Volunteers, facility and outreach clinics for provision of long acting and permanent methods. Christian Health Association of Kenya also delivered family planning services through a special interest group of community members- religious groups. The Division of Reproductive Health and the Division of Community Health Services in the Ministry of Health conducted service quality assessment for services provided by the project partners to ensure they were up to standard and in line with community strategy.

The Center for the Study of Adolescence targeted in- and out-of-school youths aged 15–24 years on adolescent sexual and reproductive health, while Forum for African Women Educationalists sensitized in-school adolescent girls on adolescent sexual and reproductive health and rights. All implementing partners were involved in demand creation on family planning/reproductive health services and capacity building of service providers on long acting and permanent methods. Marie Stopes Kenya and Family Health Options Kenya trained Community Health Volunteers and service providers in Siaya and Busia respectively in addition to training of youths on magnet theater group by Family Health Options Kenya. Christian Health Association of Kenya trained religious leaders, CHV and service providers; Center for the Study of Adolescence trained in and out of school youths, CHV and service providers, and Forum for African Women Educationalists focused mainly on adolescent girls, teachers and parents. Great Lakes University of Kisumu developed an information system for monitoring and evaluation, and conducted routine supervision of data collection, entry, and analysis. These data were generated on a monthly basis and presented to partners to facilitate reporting.

The project achieved several milestones during the reporting period, including: 1) Conducting initial and refresher training to 600 CHV on family planning technical module, counseling and distribution of short-term family planning methods. 2) Training more than 160 service providers including medical officers from public and private facilities on contraceptive technology updates and commodity management skills. 3) Training of 30 service providers, 175 CHV and 30 Community Health Extension Workers on the provision of youth-friendly services and 799 in- and out-of-school youths as peer advocates for life skills. The peer advocates for life skills conducted outreach, drama shows, and sporting activities to reach more youth with correct information on family planning/sexual and reproductive health information. The peer advocates for life skills in school provided mentoring to primary school youth. Forum for African Women Educationalists Kenya trained 103 teachers, 101 community members, 149 health workers and youths on adolescent sexual and reproductive health and rights, using the 2006 adolescent reproductive health and life skills curriculum. In addition, they trained 150 community leaders/facilitators as trainers of trainers to sensitize community leaders and parents around 35 schools on their role and responsibilities in supporting adolescent sexual and reproductive health and rights among the youth.

Over three years, the project recruited 46,353 new users to family planning (excluding those served with condoms). Most of these clients were served through community-based distribution by the CHV. The project's community-based distribution activities further influenced positive

switching behavior, with a majority of clients switching from short-acting contraceptive methods to long-acting and permanent methods: indicating an increased level of partner discussion and positive change in community attitudes towards family planning. Family planning distribution outlets were also increased from the very few static public and private health facilities to 600 mobile CHV distributing door-to-door and from 10 mobile outreach clinics conducted on a monthly basis.

During the period under review, the project also recorded several major achievements. For instance, in January and November 2014, the project through the Division of Reproductive Health and Division Community Health Services conducted two successful quality assessment visits to activities implemented by partners to ensure standardization and quality of service. In November 2013 and January 2016, the project partners presented at two International Conference on Family Planning events in Ethiopia and Indonesia, and in three Great Lakes University of Kisumu conferences every April from 2013 to 2015. Quarterly county stakeholders' meetings were held to disseminate key project achievements, lessons learned, challenges, and best practices. The project partners also conducted five county advocacy meetings, one in each county: Siaya and Busia in February 2014, and Kakamega, Bungoma and Homabay in July 2015. These county advocacy meetings with the county leadership created a platform for sharing of the project achievements and lessons as well as advocating for support of family planning among the county leaders. In 2015, a courtesy call was paid to the County Director of Education and the Teachers Service Commission County Director in Busia. Inputs in the meeting are currently under consideration in the development of the adolescent sexual and reproductive health and rights curriculum by the Kenya Institute of Curriculum Development.

The project also conducted sensitization visits to 215,638 households and 8,085 community meetings, reaching 213,758 and 402, 068 people with family planning/reproductive health information. In addition, the consortium printed and distributed information education and communication materials; created social media platforms, project banners, posters, and talking walls at schools; and supplied branded caps, T-shirts, method bags, and bicycles to deliver family planning/reproductive health information. The consortium collaborated with the county governments to sponsor Busia and Siaya county stakeholders' meetings, where they shared project activities with other reproductive health partners and the Ministry of Health at the county level.

Finally, the consortium participated in World Contraception Day celebrations where, in collaboration with the county ministries of health, we sensitized women and offered family planning services to clients. The consortium also revived data quality audit meetings in Siaya and Busia counties to harmonize data, a process that has since been repeatedly adopted by the team from the county health records and information officers to harmonize partner and ministry data and leveraged resources to co-finance other project and government activities.

CHAPTER 1
INTRODUCTION

INTRODUCTION

Project overview

The Reversing the Stall in Fertility Decline in Western Kenya Project, also referred to as the Packard Western Kenya Project, is a community-based family planning initiative implemented in two large western Kenyan counties: Busia and Siaya.

The project was funded by the David and Lucile Packard Foundation and builds on the lessons and achievements of a demonstration project phase, which ran from November 2009 to September 2012. The demonstration project covered Busia and Siaya districts (later counties) which, as of September 2012, had an estimated total population of 1.654 million (739,000 in Busia and 915,000 in Siaya). These counties had the highest fertility rates in the country at an average total fertility rate (TFR) of 5.5 against a national TFR of 4.6. Modern contraceptive use prevalence in the two areas stood at around 32% [1].

The Reversing the Stall in Fertility Decline in Western Kenya Project is implemented by a consortium of partners with diverse strengths. The implementation model allows partners to oversee and implement aspects of the project in which they have expertise. The consortium is led by the African Population and Health Research Center (APHRC), which coordinates all project activities. Marie Stopes Kenya (MSK) and Family Health Options Kenya (FHOK) are responsible for service delivery in Busia and Siaya respectively. The Great Lakes University of Kisumu (GLUK) is responsible for the monitoring and evaluation of project activities. The team also works in close collaboration with the Ministry of Health (MoH) at the county government and national government levels; the Centre for the Study of Adolescence (CSA), which works with youth; the Forum for Women Educationalists (FAWE) Kenya, which works with school-going youth; and the Christian Health Association of Kenya (CHAK), which works with religious leaders and groups.

The expansion phase of this project began on October 2012, seeking to bring to scale activities that had been started in the demonstration phase (2009–2012). These activities included:

- Capacity-building through the training of service providers, peer educators, religious leaders, Community Health Volunteers (CHVs) and community members
- Delivery of family planning (FP) services at community facilities and through outreach activities.
- Generating demand for FP services through community sensitization meetings, e.g., *barazas*, women's and youth group meetings, distribution of information education communication (IEC) materials and use of social media
- Advocacy, policy engagement and influencing policy through advocacy meetings and distribution of advocacy materials
- Monitoring, documenting and disseminating the project's achievements, lessons and best practices.

Project goals and objectives

The project's long-term goal is to improve general health status in the target communities through reducing unwanted and mistimed pregnancies, unsafe and illegal abortions, maternal morbidity and mortality, and the fertility rate. The medium-term goals were to:

a) Increase routine use of modern contraceptive methods among women of reproductive age by eight percentage points during a three-year period; and

b) Reduce the preferred family size and influence fertility intentions among women and men.

These goals were to be achieved through:

a) Improved supply of FP services at community and facility levels through community-based FP distribution by CHVs and mobile outreach services;

b) Generating demand for FP services through effective community mobilization and outreach activities and the distribution of IEC materials;

c) Advocating for a supportive policy environment for FP programs through championing more resource allocation of the county health budget to FP and empowering communities to reject socio-cultural norms promoting early marriage and preference for large family sizes; and

d) Monitoring and dissemination of the project's achievements and lessons learned at the county and national levels.

The above project objectives were achieved through community-based distribution (CBD) of contraceptives, facility-based and mobile outreach FP services, and demand creation activities. However, the expansion phase of the Reversing the Stall in Fertility Decline in Western Kenya Project also extended the strategy used in the demonstration phase to include the private sector in the delivery of FP services. Advocacy activities were geared towards mobilizing policymakers

Table 1: Fertility trends by region, 1989-2009.

Province	Total fertility rate					Fertility status
	1989	1993	1998	2003	2009	
Nairobi	4.2	3.4	2.6	2.7	2.8	Stalled
Central	6.0	3.9	3.7	3.4	3.4	Stalled
Eastern	7.2	5.9	4.7	5.1	4.4	Declining
Rift Valley	7.0	5.7	5.3	5.8	4.7	Declining
Coast	5.4	5.3	5.0	4.9	4.8	Declining
Nyanza	6.9	5.8	5.0	5.6	5.4	Stalled[2]
Western	8.1	6.4	5.6	5.8	5.6	Stalled[3]
Kenya (total)	**6.7**	**5.4**	**4.7**	**4.9**	**4.6**	**Stalled**

[1]Nyanza and Western provinces were the areas of focus identified at the beginning of this project.
[2]Same as above.

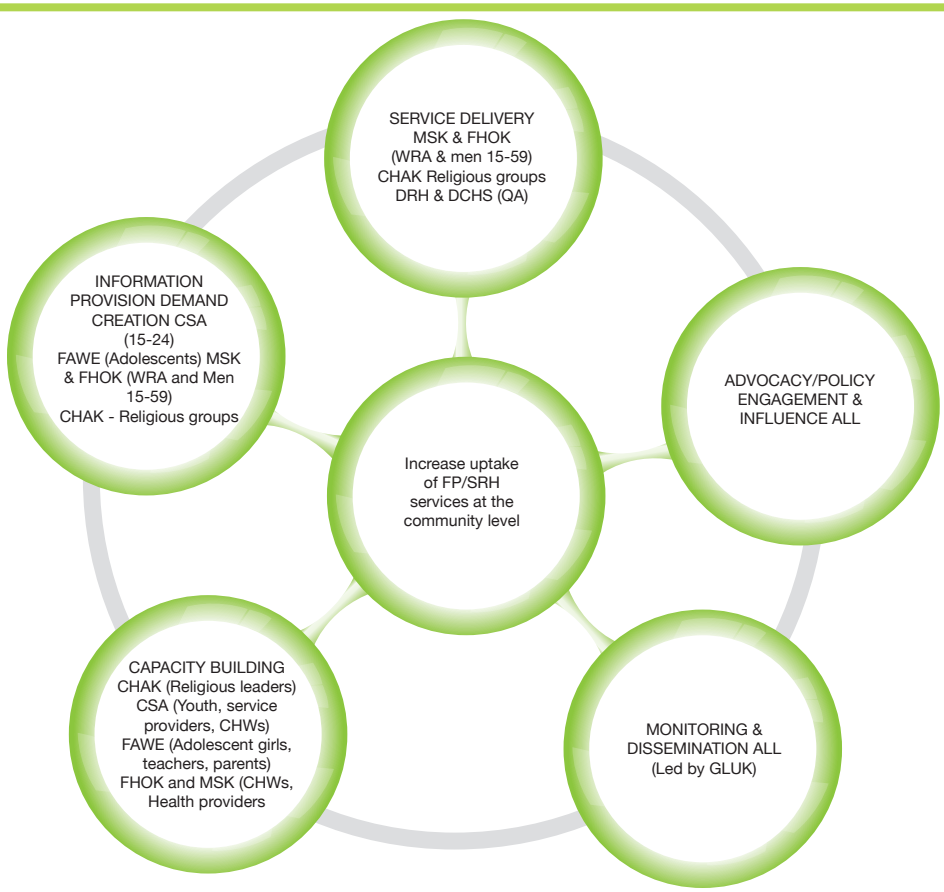
at the county level to dedicate more resources to FP and towards influencing communities to embrace positive attitudes to FP and shun negative socio-cultural practices. This phase further increased the number of CHVs from 374 in Phase 1 to 600 in Phase 2 and further expanded the locations covered to increase the depth and coverage of CHV activities.

Table 1 above provides justification for implementing this project in Western and Nyanza provinces, which, by 2009, were still experiencing a stall fertility decline.

Program structure

The project was implemented by a consortium of partners with strengths in different areas of approach. A clear implementation model was designed to guide the partners' work and engagement (both within and outside the consortium) and to provide a clear set of distinct roles and responsibilities aimed at achieving the same goals but tailored to partners' strengths to avoid duplication of effort.

Figure 1: The project implementation model. APHRC was in charge of overall coordination of partner activities.



The project activities were implemented by different partners within the consortium. Each partner had specific roles, all geared towards achieving a common objective: increasing the uptake of family planning/reproductive health (FP/RH) services at the community level. APHRC was in charge of the overall coordination of partners' activities. MSK and FHOK delivered services to all the women and men of reproductive age in Busia and Siaya counties, respectively, at the community level through CBD or facility and outreach clinics. CHAK delivered FP services to and through religious groups. The Division of Reproductive Health (DRH) and the Division of Community Health Services (DCHS) in the Ministry of Health, Government of Kenya, were involved in the service quality assessment for services provided by the project partners to ensure they were up to standard and in line with community strategy.

The provision of information in order to create demand involved community sensitization on various FP/RH services. MSK and FHOK conducted sensitization of all women of reproductive age, men aged 15–59 years and youth in organized groups. CSA educated in- and out-of-school youths aged 15–24 years on adolescent sexual and reproductive health (ASRH). CHAK sensitized religious groups on RH issues while Forum for African Women Educationalists (FAWE) educated school going adolescent girls about adolescent sexual and reproductive health and rights (ASRHR).

Capacity-building activities included training service providers to deliver high-quality FP services and to conduct sensitization, counseling and referrals. All implementing partners were involved in capacity building. CHAK trained religious leaders, Community Health Volunteers and service providers. CSA trained youth, youth service providers and Community Health Volunteers. FAWE trained adolescent girls, teachers and parents. FHOK and MSK trained Community Health Volunteers and volunteers, and service providers. FHOK also conducted targeted training for youth using the Magnet Theater Group.

All partners played a role in monitoring and dissemination, led by GLUK. This involved designing data collection tools and monitoring information systems (MIS), data collection, data entry, and data analysis and interpretation. These results were disseminated in various stakeholders' meetings workshops and conferences. Led by APHRC, all partners, were also tasked with advocacy and policy engagement. Generally, advocacy and policy engagement and knowledge translation involved conducting meetings with policymakers in the counties to share evidence and to attempt to inform certain policy shifts in favor of family planning.

CHAPTER 2
KEY PROJECT ACTIVITIES

KEY PROJECT ACTIVITIES

The following were the main project activities undertaken to achieve the project objectives in Busia and Siaya counties.

Improving supply of FP services

Training of service providers, community health volunteers (CHVs), youths, community health extension workers (CHEWs), etc.

Training Community Health Volunteers to provide short-acting family planning methods

The project recruited and trained CHVs to deliver high-quality family planning services, these being mainly the provision of contraceptives in the form of condoms and pills, including emergency contraceptives. The training covered the basic concepts of family planning, use of FP methods, precautions and side effects, and how to keep simple records and report the information to their supervisors and link health facilities. The CHVs conducted counseling on FP methods and the referral of clients to the nearest health facilities, partner clinics and mobile outreach for long-acting and permanent methods (LAPM) and other RH services. In addition, they also conducted follow-ups with clients for any further services.

Training service providers to deliver quality LAPM and commodity logistics management

The project recruited and trained service providers from public and private health facilities to provide long-acting reversible contraceptives (LARCs) and permanent methods, including Implanon NXT. The implementation partners (MSK and FHOK) also conducted continuous on-the-job training of medical officers on permanent contraceptive methods, i.e., bilateral tubal ligation (BTL) and vasectomy. This training was aimed at increase the number of service providers with competency and proficiency in providing long-term family planning methods, and implementing a sustainable family planning program in Siaya and Busia counties. The project also trained service providers on contraceptive commodity management to streamline consumption and supply requests in order to ensure timely and adequate requests for commodities.

Mobile outreach services for provision of LAPM

The partners established two independent outreach teams, each comprised of two medical doctors, one from MoH and the other from a partner organization; two nurses; and one nurse aide. The partners also purchased sets of insertion equipment and the supplies necessary to offer the full range of FP services, including bilateral tubal ligation (BTLs) and vasectomies, at rural health facilities. Each team conducted at least four mobile outreaches per month on a rotational basis. All BTL and vasectomy outreaches were moved from the central district health

facilities and main clinics to the peripheral health facilities where residents could easily access them without having to travel long distances.

Procurement of buffer stock and redistribution of FP commodities during stock-outs

The implementing partners procured buffer stock to supplement FP commodities during stock-outs. These commodities were distributed to government health facilities whenever there was a shortage and were also used during mobile outreaches to ensure a consistent supply of FP commodities and services in Siaya and Busia counties. In addition, the partners conducted FP commodity redistribution amongst health facilities in an effort to minimize the risk of stock-out in some facilities.

Demand generation for FP services

Sensitization meetings by the CHVs, e.g., theater groups, women's group meetings, youth group meetings, *barazas* and others

CHVs were involved in creating demand for family planning services through FP counseling during door-to-door household visits. They also targeted men and women at various community meetings including community ***barazas***, women's group meetings, youth group meetings, churches, market places and funerals. The CHVs also targeted women at various health events like health camps and globally recognized annual advocacy days such as World Contraception Day, World Breastfeeding Week, Nurses' Week, and World Malaria Day. The CHVs conducted health talks and performed theater shows, songs, poems and role plays on family planning. They also held community dialogue days within their villages through their respective community units (CUs) to identify community FP services, needs and possible ways of addressing these needs. The CHVs were also supplied with various IEC materials on FP/RH, e.g., fliers, posters and pamphlets.

A team of youths from the Magnet Theater Group was also selected and trained to sensitize people through edutainment activities, role-plays and drama during community meetings. The youths were supplied with public address systems, which they used while performing. The messages delivered focused mainly on family planning. This demand creation approach was expected to be effective in attracting crowds and motivating them to adopt FP services.

Monitoring and evaluation; development of the M&E system; review of tools and the system; data and data flow procedures

Baseline survey

At the beginning of Phase 1 of this project in 2010, a baseline survey was conducted in the project areas to provide information about the knowledge and use of contraception, sources of contraceptives, attitudes and common beliefs about family planning, and the perceived availability and accessibility of FP services at the community level. The survey obtained detailed data on fertility preferences, awareness and use of family planning methods, childhood mortality, and more maternal and child health indicators. Data from this baseline survey was expected to be of use in assessing the impact of project interventions.

Monitoring information system

The program developed and later redesigned reporting tools for data collection at service delivery points and a monitoring information system (MIS) that captured key project indicators following a rapid appraisal of the Phase 1 project conducted in April 2013. These tools were utilized by the CHVs and service providers to record data on persons reached with FP services and information. These tools were printed in triplicate, with one copy for the health facility, one for the partners and one retained by the CHV/service provider. The MIS was then stationed at GLUK to capture data generated during the expansion phase. To ensure data quality control, training was conducted for all M&E staff, including data entry clerks, on the new system. The entry and analysis of monitoring data from the MIS was done on a monthly basis to determine progress in achieving the project indicators against defined targets. This data was summarized in simple reports and shared with partners on a monthly basis.

Data capture and flow

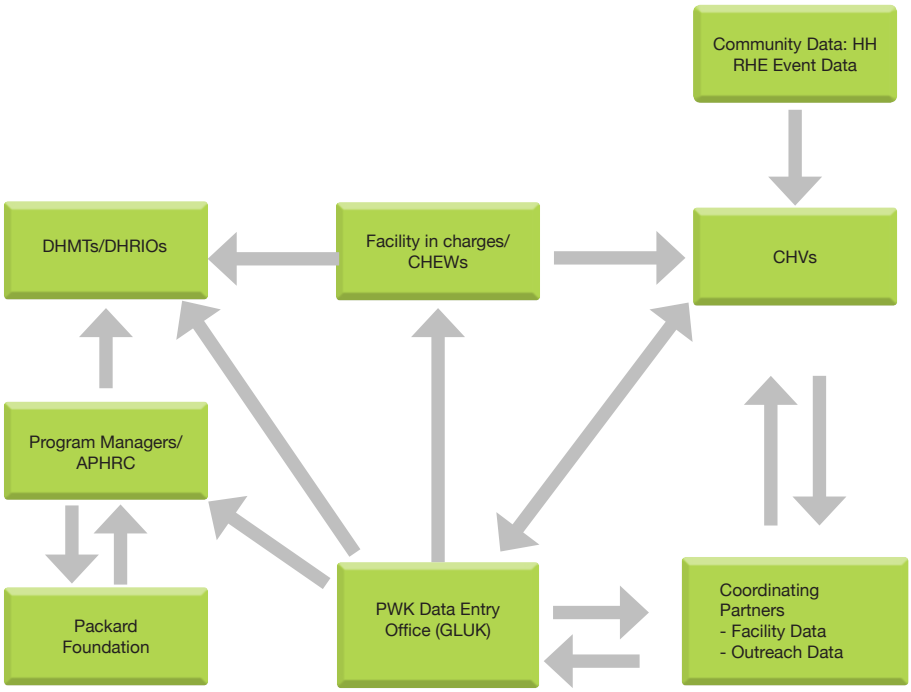
The copy of a Packard Western Kenya (PWK) project report sent to the health facility would be summarized and captured on the MoH FP register stationed at the facility level and channeled to the sub-county health records and information officer, and to the MoH system. The copy to partners would be sent for entry into the MIS stationed at GLUK and analyzed, and the statistics sent to partners to complete their reports, which were sent to APHRC and finally to the Packard Foundation. CHVs monthly review meetings were held to review data, set targets and make corrections before submission to the project coordinators. On a quarterly basis, partners organized review meetings to deliberate on project progress, including achievements and challenges, according to the data from the MIS. They would further develop acceleration plans on indicators that were lagging behind. Furthermore, CSA had an online M&E system where data was fed in and analyzed. Tools used for data collection included satisfaction cards, which were available at the health facilities, and the reporting tool for the peer advocates for life skills (PALS), both in and out of school.

End of project evaluation

Packard Foundation contracted Mathematica Policy Research as their monitoring, evaluation, and learning advisor to conduct an end-of-project evaluation of the Packard Western Kenya Project. The consortium partners worked with the evaluation team, to provide information to assist their assessment of progress towards project goals.

The evaluation exercise began mid-October 2015 and involved conducting interviews with the project beneficiaries within the facilities' catchment areas, with health facility staff, CHV and CHEW who have received training and support through the project. The evaluation could provide important insights on how the interventions are working, the key facilitators of and barriers to their successful operation and scale-up, and the extent to which the project could be integrated into existing government structures and systems.

Figure 2: Diagram showing data capture and flow



Dissemination activities: conferences, stakeholders' and partners' meetings

The PWK monitoring data generated key project indicators, summarized in simple reports and shared with the partners on a monthly basis. From these reports, the partners derived key project achievements, challenges, lessons learned and best practices, which were disseminated in various forums including local and international conferences, county stakeholders' meetings, community meetings and meetings with other RH stakeholders. This encouraged the adoption of the project design in the implementation of other programs by other partners, and advocated for resource allocation to family planning programs at the county level through the county governments for sustainability.

Publications: journal articles, reports, policy briefs, fact sheets, infographics, blogs, etc.

The project provided continuous monitoring and dissemination of the project's achievements and the lessons learned at the county and national levels, though partners' websites and newsletters, national, regional and international conferences, and through other gatherings and national technical working groups.

Advocacy activities

County health management team (CHMT) meetings and activities, policy engagements, advocacy materials, etc.

The consortium organized two major successful county advocacy meetings on February 19-20, 2014 to lobby for county resource allocation to family planning programs for sustainability. The project also held 17 stakeholders' meetings (involving county and sub-county health management teams and reproductive health partners) on a quarterly basis to share project achievement, challenges and lessons learned. The project consortium partners also funded and participated in various national health days like World Contraceptive Day and Breastfeeding Week, which are celebrated yearly to campaign for family planning and encourage communities to promote use of modern FP services. CHVs also wore branded T-shirts and caps, used branded bicycles, and carried branded method bags bearing catchy messages such as the project's tagline ***"Jamii ndogo: Jimudu"*** (Small family size: self-sufficiency), a powerful slogan that encouraged positive associations with use of family planning. The partners regularly made courtesy calls to sub-county health management teams (SCHMTs) through joint visits by Packard Foundation staff and the implementing partners. During these courtesy calls, discussions on how the project would best continue to support and complement the government's FP initiatives were discussed.

CHAPTER 3
PROJECT ACHIEVEMENTS

PROJECT ACHIEVEMENTS

Increasing supply of FP services (number reached with FP services at community, facility and outreach level)

Use of FP and improved FP/RH practices

Results from the 2014 Kenya Demographic and Health Survey (KDHS) show that there has been a significant improvement in major family planning indicators in Busia and Siaya counties. There has been a noticeable increase in the prevalence of modern contraceptives: 51% in Siaya County and 57% in Busia County, up from 33% in Nyanza Province and 41% in Western Province in 2008/9.

Table 2: Changes in fertility and use of FP in Busia and Siaya counties between 2008/9¥ and 2014

		Year	
	Region	**2008/9**	**2014**
TFR (Mean)	Busia Siaya National	5.6 5.4 4.6	4.7 4.2 3.9
Any method CPR (%)	Busia Siaya National	47 37 46	58 55 58
Modern CPR (%)	Busia Siaya National	41 33 39	57 51 53
Unmet need for FP (%)	Busia Siaya National	26 32 26	21 23 18

¥Data for 2008/2009 was collected at province level, therefore this represents the results for Western (for Busia) and Nyanza (for Siaya) provinces

There has also been a major drop in the rates of fertility in the regions. Total fertility rates have dropped to 4.2 in Siaya and 4.7 in Busia, down from 5.4 in Nyanza and 5.6 in Western provinces in 2008/9. There has also been a significant drop in unmet need for FP to 23% in Siaya and 21% in Busia, down from 32% in Nyanza and 26% in Western provinces in 2008/9 [1, 2]. Immediate project outcomes from the PWK Project could be attributed to the increase in the contraceptive

prevalence rate (CPR) in Siaya and Busia counties. It is anticipated that the evaluation exercise will determine and document this contribution.

Improved capacity of health providers to provide FP/RH

Six hundred CHVs (275 in Busia and 325 in Siaya) underwent initial and refresher training on the FP technical module and on counseling on and provision of short acting contraceptive methods. CHVs were involved in the community-based distribution of pills and condoms and referral of clients to health facilities and mobile clinics for LAPM.

Practical demonstration session of IUCD insertion during service providers' training

A total of 164 service providers (91 in Busia and 73 in Siaya) were trained on contraceptive technology update (CTU) and FP commodity management skills.

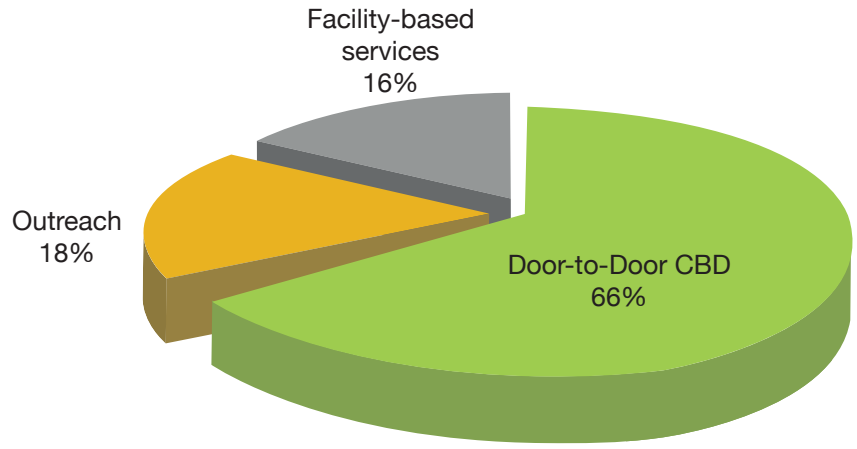
This involved a five-month mentorship for three medical officers on how to support women to use permanent contraceptive methods. These service providers delivered long acting reversible contraception and permanent methods to clients at health facilities and outreach clinics.

The Center for the Study of Adolescence trained 30 service providers (14 in Busia and 16 in Siaya), 175 CHVs (105 in Busia and 70 in Siaya) and 30 CHEWs on the provision of youth-friendly services (YFSs). The CHEWs provided a link between the community and the health facilities. In addition, 799 in- and out-of-school youths were trained as PALS. The PALS were involved in conducting outreaches, drama shows and sporting activities to reach more youth in the community with correct FP/sexual and reproductive health (SRH) information. The PALS in school provide mentorship to younger youths in primary schools. FAWE Kenya trained 103 teachers, 101 community members, 149 health workers and youths on ASRHR. In addition, they trained 150 community leaders/facilitators as trainers of trainers (ToTs) to sensitize community leaders and parents around 35 schools on their role and responsibilities in supporting ASRHR among the youth.

Improved supply of and access to FP services

Through the project's activities, the number of clients using contraceptive methods was increased. A total of 46,353 new users to FP (excluding 51,569 new clients who were served with condoms only) were recruited. The majority of these clients (66%) received FP methods through door-to-door community-based distribution (CBD) (30,758), 18% during outreaches (8,395) and 16% through facility-based services (7,200).

Figure 3: Channel for improved supply of and access to FP services



The different approaches yielded varying results in the two counties. In Siaya County, only slightly over half of all new FP users were recruited through CBD compared to almost 80% of new users in Busia. Facility-based distribution performed better in Siaya, accounting for 29% of new users compared to only about 3% of new users in Busia. Interestingly, outreach activities did not have any differential contribution between the counties.

In total, 78,887 clients (both new and revisiting clients) received pills (31,331 in Siaya and 47,556 in Busia), 121,372 clients received condoms (65,920 in Siaya and 55,452 in Busia). Further, 2,240 clients received intrauterine contraceptive devices (IUCDs) (869 in Siaya and 1,371 in Busia). There were also 57 IUCD removals in the two counties, three quarters of which were done in Busia County. There were, in addition, 19,745 implants inserted, which were split almost evenly between the two counties. Over the same period, 767 implant removal procedures were undertaken; the majority (63%) were conducted in Busia County.

Altogether, 1,634 clients received BTL services (537 in Siaya and 1,097 in Busia). Interestingly, almost 70% of these BTL clients were revisiting clients. There were 46 vasectomies conducted in Siaya and Busia counties over the project period, with over 85% of these conducted in Busia County. Finally, 16,257 clients received injectable contraceptives (13,475 in Siaya and 2,782 in Busia). The high uptake of injectable contraceptives in Siaya was mainly driven by facility-based distribution, while about 60% of injectables in Busia were distributed through outreach programs.

The uptake of IUCD and vasectomy remained low, mainly due to myths and misconceptions about these methods in the two regions. In Siaya, for instance, vasectomy was equated to male castration.

Distribution outlets were increased from the very few (101) static health facilities to include distribution at household level and through outreach clinics. Other than static health facilities,

clients obtained family planning commodities from the 600 CHVs distributing door-to-door and from 10 mobile outreach clinics conducted on a monthly basis.

Positive switching behavior from short-acting contraceptive methods to LAPM was also noted during the project implementation period, which indicated an increased level of partner communication about family planning and changing attitudes to family planning. The majority of clients who adopted short-acting contraceptive methods like pills and injectables were found to have used the same methods previously. A higher percentage of women switched from short-acting contraceptive methods to LAPM, as shown in Table 3 below.

Table 3: Contraceptive switching behavior among clients served with long-acting and permanent methods (BTL, implants and IUCDs), by percentage

	New method		
Method formerly used	**BTL**	**Implants**	**IUCD**
Pills and injectables	54	46	46
No method (new to FP)	26	46	41
Other methods	20	8	13
Number of clients	**1,634**	**19,745**	**2,240**

However, clients who adopted short-acting contraceptive methods more often either maintained their usual method, were not been using any method before, or had been using another short-acting method, as shown in Table 4.

Table 4: Contraceptive switching behavior among clients served with short-acting methods (pills and injectables), by percentage

	New method	
Method formerly used	**Pills**	**Injectables**
Pills	49	51
No method (new to FP)	42	39
Injectables	7	7
Other methods	2	3
Number of clients	**78,887**	**16,257**

Program implementation quality assessment

The project partners, in collaboration with two main divisions in Government of Kenya Ministry of Health namely the Division of Reproductive Health (DRH), and the Division of Community Health Services (DCHS) and representatives of the county health management teams conducted quality assessment exercises in Busia and Siaya counties in January and November 2014, respectively. The objectives of the assessment were to show community linkage and coordination structures;

to conduct service quality assessment for Packard-supported LAPM outreach services; to assess facility readiness for provision of family planning services; to identify strengths and areas of improvement for outreach services; and finally, to provide feedback on the standardization of FP services by the Reversing the Stall in Fertility Decline in Western Kenya Project to the MoH. The DRH provided overall technical oversight on the quality of clinical services, while the DCHS provided guidance in line with the implementation of community health strategy.

Three tools were used for the assessment:

a) **An integrated facilitative supervision tool** (capturing all the services offered) for RH services used to assess the quality of services provided by the health care providers,

b) **A community assessment tool** used to assess the quality of services provided by the CHVs at the community level, and

c) **An outreach tool** used to assess the quality of FP services offered at outreaches.

After the exercise, the assessment teams compiled and shared key findings, areas of improvement and recommendations to the project partners.

LEFT: *A meeting with CHVs at a dispensary during the quality assessment activities in January 2014. RIGHT: A team of doctors preparing for BTL service provision at a hospital in Siaya, together with a quality assessment officer.*

Numbers reached with FP information/demand generation activities

Improved demand for FP services through effective outreach activities and distribution of IEC materials

Throughout the period of this project, 215,638 households were visited (Siaya 121,667 and Busia 93,971) reaching 213,758 people within the target age groups (Siaya 110,647 and Busia 103,111) with FP information through door-to-door household visits. In other meetings, 8,085 (Siaya 2,689 and Busia 5,396) community meetings were attended reaching out to 402,068 men and women (Siaya 120,426 and Busia 281,642) with FP messages.

Further approaches were used to deliver FP messages and create demand among these groups. The project designed two project banners displaying all the project partners and the project slogan, *"Jamii ndogo: Jimudu" (Small families: self-reliance)*. This message was eye-catching and aimed to encourage women to embrace smaller families. CHV were, in addition, supplied with IEC materials, including fliers, posters and FP booklets, and branded stickers, T-shirts, caps, method bags, and bicycles to aid in sensitization activities.

Some partners, such as CSA, also used social media to conduct their activities. CSA developed and maintained a Facebook page where youth could pose questions on ASRHR issues. CSA also conducted four community dialogue sessions in the four sub-counties, where 100 community gatekeepers were sensitized on FP. The gatekeepers appreciated the effort and went further to form community working groups, which talked to communities during community dialogue days. These meetings were conducted together with the CHVs and CHEWs. An additional 1,000 young people were reached with information on FP through edutainment activities organized by the youth in Siaya and Busia. Other partners, like FAWE Kenya, produced various IEC materials for dissemination of key messages on ASRHR to youth: 2 pull-up banners, 1 wall banner, 4,000 brochures, 1,000 flyers and 747 T-shirts were used to sensitize approximately 3,000 youth on ASRHR.

Monitoring and evaluation

The tables and charts below summarize key achievements on select project indicators. In order to show progress towards improved demand for FP services through effective outreach activities and distribution of IEC materials, the program monitoring and evaluation framework developed by the partners tracked the following indicators: the number of new and revisiting FP clients, both to FP generally and to this project for pills, condoms and a combination of pills and condoms; the number of referrals made by CHVs for FP services such as IUCDs and implants insertion and removal, BTL, vasectomy and Depot medroxyprogesterone acetate (DMPA); and the number of outreaches conducted.

Clients reached and supply of family planning commodities

Table 5 shows the summary of statistics for these indicators over the reporting period, as discussed in the preceding sections.

Table 5: Clients reached and supply of family planning commodities

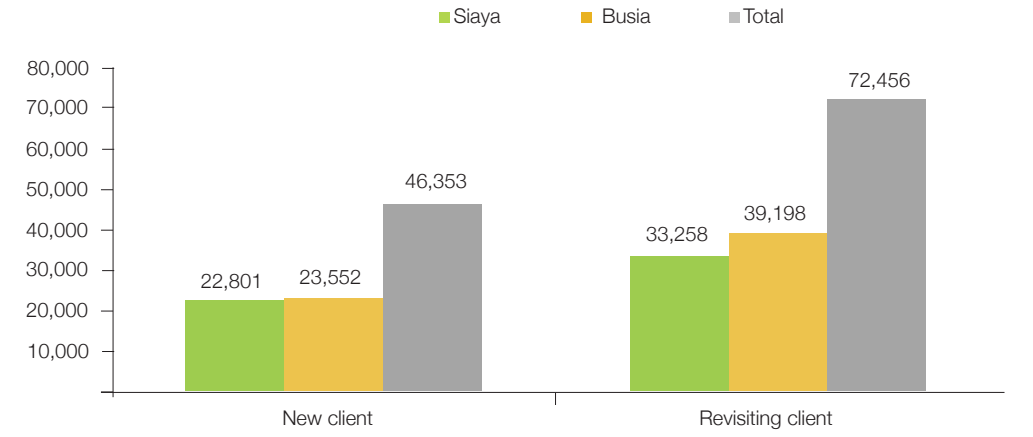
		Siaya				Busia				
		Community	Facility	Outreach	Total	Community	Facility	Outreach	Total	Total
Clients	Clients new to FP	48,214	6,764	9,607	64,585	61,704	867	2,941	65,512	130,097
	Clients revisiting FP	68,126	9,459	5,101	82,686	86,111	1,718	6,929	94,758	177,444
	Clients new to project	52,249	9,143	12,841	74,233	65,488	1,278	5,804	72,570	146,803
	Clients revisiting project	59,495	7,070	1,684	68,249	54,424	1,306	4,089	59,819	128,068
Pills	Clients new to pills	10,821	511	124	11,456	18,412	148	12	18,572	30,028
	Clients revisiting pills	16,278	552	108	16,938	28,212	194	17	28,423	45,361
	Pills total cycles	58,309	2,328	455	61,092	123,149	820	63	124,032	185,124
Condoms	Clients new to condoms	22,784	293	5,478	28,555	22,787	205	22	23,014	51,569
	Clients revisiting condoms	32,353	193	1,882	34,428	31,718	147	12	31,877	960,799
	Condoms total pieces	2,583,082	24,739	163,441	2,771,262	1,467,176	8,645	820	1,476,641	4,247,903
Pills and condoms	Clients new to pills & condoms	1,316	18	12	1,346	209	1	1	211	1,557
	Clients revisiting pills & condoms	1,552	26	13	1,591	340	3	7	350	1,941
	Total quantity pill cycles	7,898	4,171	121	12,190	1,403	10	22	1,435	13,625
	Total quantity condoms	138,968	404	731	140,103	12,333	100	220	12,653	152,756
Referrals	Total Referrals	30,888	12,164	6,635	49,687	47,166	2,287	9,713	59,166	108,853
	Total referrals for LARCs	24,870	12,712	6,592	44,174	42,111	1,796	9,461	53,368	97,542
	Total referrals for RH	362	1,186	1	1,549	1,198	43	98	1,339	2,888

		Siaya				Busia				
		Community	Facility	Outreach	Total	Community	Facility	Outreach	Total	Total
IUCD	IUCD insertion for new clients	-	250	217	467	-	20	376	396	863
	IUCD insertion for revisiting clients	-	183	219	402	-	61	914	975	1,377
	IUCD removal for clients	-	6	9	15	-	6	36	42	57
Implants	Implant insertion for new clients	-	2,250	3,390	5,640	-	251	2,986	3,237	8,877
	Implant insertion for revisiting clients	-	1,586	2,614	4,200	-	344	6,324	6,668	10,868
	Implant removal for clients	-	185	98	283	-	20	464	484	767
BTL	BTLs for new clients	-	13	163	176	-	6	324	330	506
	BTLs for revisiting clients	-	36	325	361	-	34	733	767	1,128
Vasectomy	Vasectomy for new clients	-	1	7	8	-	4	14	18	26
	Vasectomy for revisiting clients	-	-	2	2	-	9	12	21	23
DMPA	DMPA for new clients	-	3,479	230	3,709	-	249	539	788	4,497
	DMPA for revisiting clients	-	6,619	3,147	9,766	-	900	1,094	1,994	11,760

New & revisiting family planning users

Between October 2012 and May 2015, 118,809 clients were reached with family planning commodities other than condoms.

Figure 4: New & revisiting family planning users (excluding condom users)

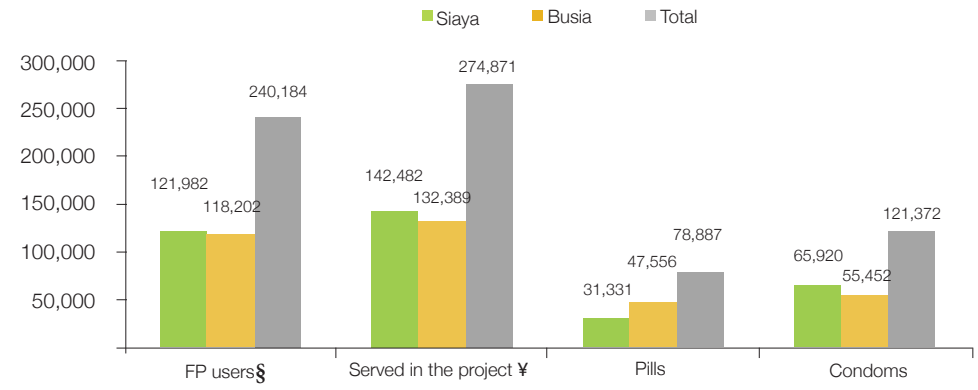


Of these, 39% (46,353) were new clients, while 61% (72,456) were revisits. There were no major differences in adoption between Siaya and Busia counties.

Total number of clients, new and revisiting, accessing FP service, by method

According to the figure below, most of the clients reached were condom and pill users. Of all FP users reached (240,184), 73% (200,259) received pills and condoms, which was 83% of all clients reached by the project.

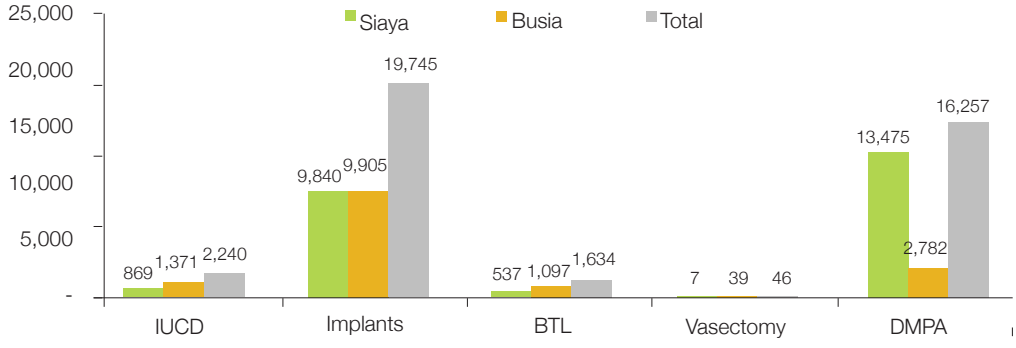
Figure 5: Total number of clients, new and revisiting, accessing FP service, by method (including condom users)



§ FP users are clients who actually adopted family planning services. ¥ Those served in the project may not have taken up a method but were served by the project; perhaps they were given information and referred

There was higher adoption of pills in Busia than in Siaya, while there was higher uptake of condoms in Siaya than in Busia.

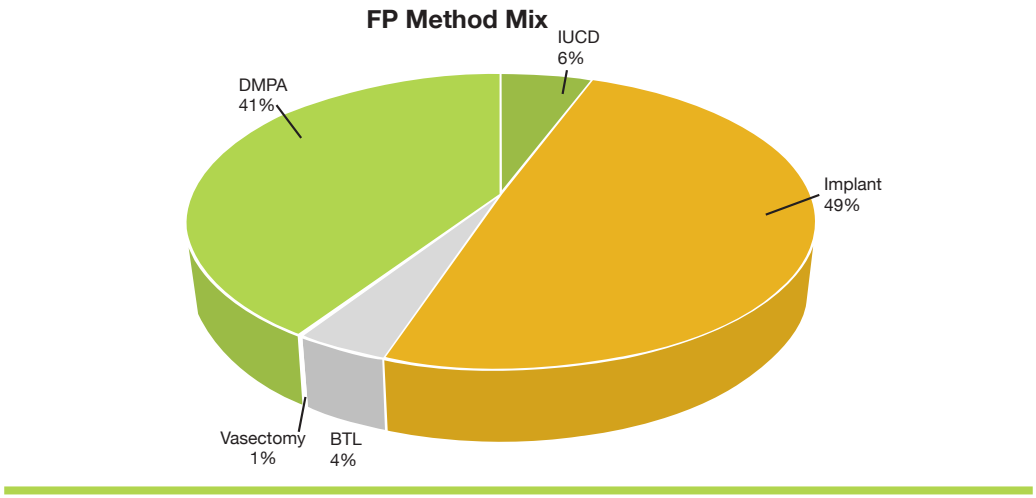
Figure 6: Clients, new and revisiting, accessing family planning services, by method[4]



In terms of different methods adopted by clients, almost half of the new and revisiting clients for IUCDs, implants, BTL, vasectomies and injectables (39,652) adopted implants, and about 41% adopted injectable contraceptives. Only about 46 vasectomies were conducted, 39 of which were in Busia, accounting for less than 0.1% of all methods adopted.

[4]The DMPA reported the figures were strictly successful referrals by consortium CHVs who routinely went to facilities and obtained injectable contraceptives. At the beginning of the project, some of the CHV in Busia did many successful DMPA referrals but failed to follow-up the health facilities to get the numbers of successful referrals. A significant amount of these referrals had been missed out by the time this was corrected. There was therefore significant under reporting of these DMPA referrals in Busia.

Figure 7: The family planning method mix, Siaya and Busia counties combined

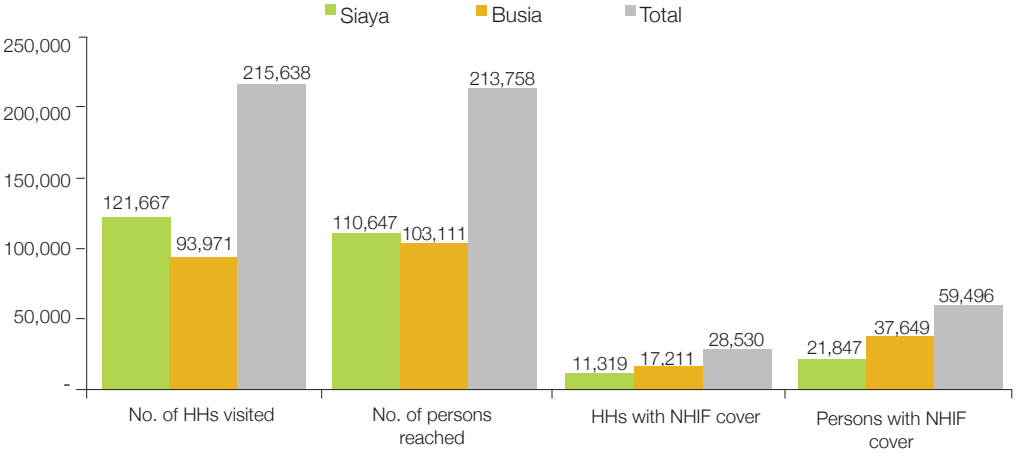


Interestingly, while the majority of injectables clients were from Siaya, more IUCD, BTL and vasectomy clients were from Busia County.

Number of persons in the household reached with FP messages

The project tracked the number of contacts that CHVs had with households (HHs), which is a measure of exposure to FP messaging: a prerequisite to adoption. Figure 8 below shows the total number of households and persons reached by CHVs with FP messaging between October 2012 and May 2015 in Busia and Siaya counties.

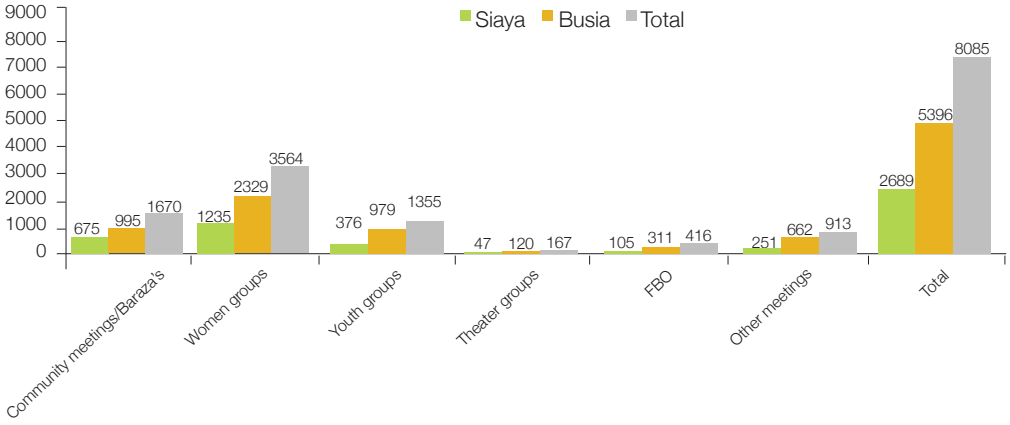
Figure 8: Number of persons in the household reached with FP messages



Number of community meetings held and attended

Over the implementation period, 8,085 community meetings were held in Busia and Siaya counties. A larger proportion of these meetings were held in Busia County (5,396) than in Siaya County (2,689). Women's group meetings topped the list with 44% of all meetings, 65% of them happening in Busia County. At the beginning, the project team planned that these meetings would be held by CHVs in one are jointly and this led to the target of 80 meetings. However, during the project implementation, every CHV was able to target women group meetings and barazas at different times of the month, which boosted the project's presence in these meetings. This led to the numbers soaring as high as over 600 meetings a month, assuming each CHV only attended one meeting.

Figure 9: Number of community meetings held and attended

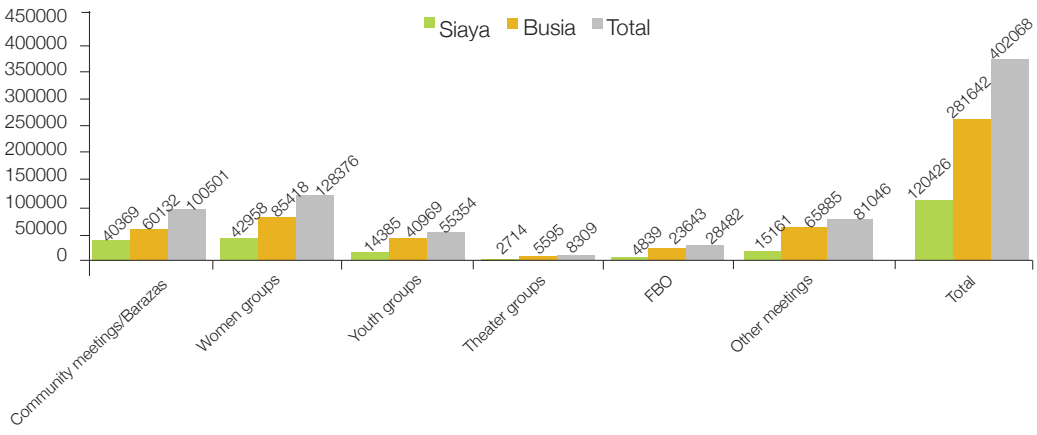


In addition, 1,670 barazas were held, 60% of these in Busia and 40% in Siaya County.

Persons reached with FP messages at various community meetings

The aim of tracking the project's participation in community meetings is mainly to know the number of women, youth and men reached through these interpersonal channels with family planning conversations.

Figure 10: Persons reached with FP messages at various community meetings



Over the implementation period, 402,068 persons were reached, 32% of these were through women's groups, 25% through ***barazas*** and 43% through other community meetings, such as youth groups, FBO services and theater groups, among others. However, these were not necessarily unique people and there might have been individuals reached more than once. Effectively, going by the population of women of reproductive age (WRA) in Busia and Siaya by 2012, this means each WRA in Busia was reached about 1.7 times over the project period, while in Siaya county, we reached about 60% of all each WRA at least once.

Persons reached through youth-specific initiatives by CSA

Our partner CSA conducted a number of activities, all geared towards increasing contact with youth in both Busia and Siaya counties. Further, these youth were reached through programs and activities that were more appealing to them and through activities which allowed them to get the information they require on pertinent sexuality issues in confidence, and from people like them – fellow youth. CSA recruited peer advocates for life skills (PALS) from youth in the community and trained them on the different aspects of reproductive health challenges that young men and women often face.

Table 6: Project achievements on youth-related indicators as at May 2015

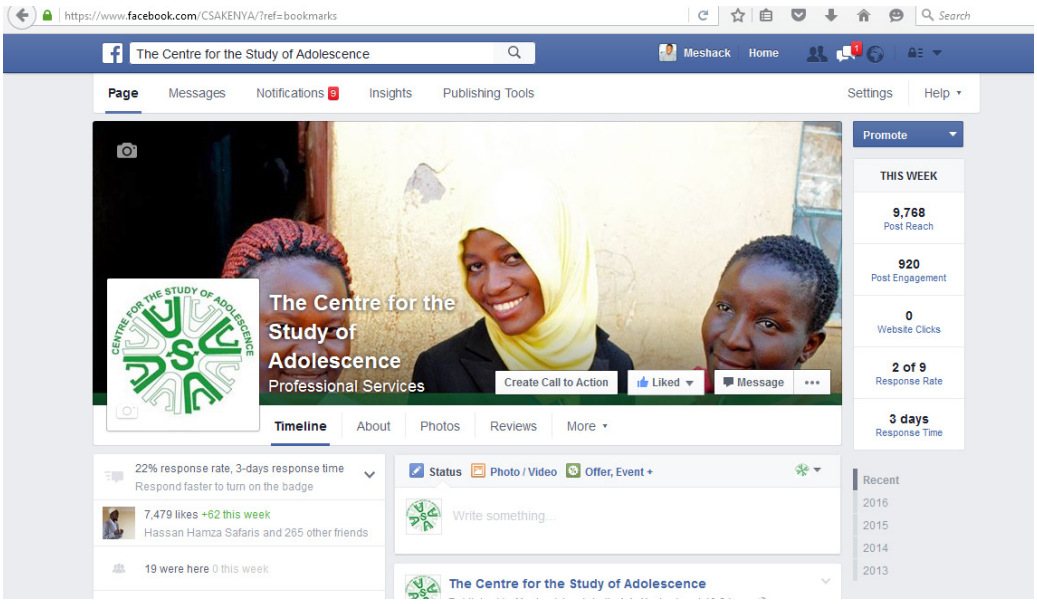
	Target	Achieved	% Achievement
In- and out-of-school youths trained as PALS	500	800	160
Magic bags† distributed	300	219	73
Schools implementing comprehensive sexuality education (CSE)	80	70	88
Active school health clubs	80	70	88
Members in school health clubs	12,000	2,040	17
Girls identified and supported to return to school	15	4	27
Nurses trained	30	30	100
CHEWs trained	30	30	100
CHVs trained	200	176	88
Peer providers trained	30	0	0
Round trips to distribute contraceptives	12	1	8
Condom dispensers produced	15	0	0
Youth rooms refurbished	15	0	0
Referrals made	3,000	990	33
Mobile clinics held	45	5	11
Satisfaction cards printed	5,000	4,000	80
Community gatekeepers sensitized	100	100	100
Community dialogues held	4	4	100
Coordination meetings held	4	0	0
Drama shows held	12	5	42
Sporting activities held	10	3	30
Fliers developed	10,000	3,500	35
Phones with airtime to access social media	25	7	28
Call-in radio programs on ASRHR supported with information	12	1	8
Young people accessing services[5]	15,000	16,500	110

1 From April 2014–June 2015 at 29 participating health facilities: Total = 600 outreaches
†Magic bags are fully stocked compartmental bags that CHVs carry while on CBD services. The bags come preloaded with methods as well IEC materials. In this project, CHVs would restock their bags from time, with supplies from the facilities they are linked to.

[5]From April 2014–June 2015 at 29 participating health facilities: Total = 600 outreaches

Overall, CSA trained 500 PALs, distributed information materials and recruited 80 schools for comprehensive sexuality education and health clubs. Through these clubs, CSA, together with the participating schools recruited 12,000 in-school youth into the health clubs. Health clubs, which meet once a week on specific school days, give teachers, especially guidance and counseling teachers to train these adolescents and youth on sexuality issues that more often cannot be taught in class during curriculum lessons.

Figure 11: Jipange- CSA Facebook page on February 10, 2016



Religious leaders as champions of FP messages

Over the last three years of implementation, this project would not have succeeded without addressing one of the major barriers to contraceptive use: religion and religious beliefs. To achieve this transformation, engagement of religious leaders was fundamental. This included Christian leaders, both Catholic and Protestant, as well as Muslim imams in Western Kenya. This arm of engagement was spearheaded by Christian Health Association of Kenya (CHAK) and facilitated a deeper penetration into the religious communities with FP information and services.

CHAK facilitated participating health facilities to deliver accessible, comprehensive, quality health services to Kenyans in accordance with Christian values and professional ethics, guided by the national health sector policies.

This arm of interventions within the PWK Project aimed at achieving the following:

- Build the capacity of faith-based health networks and workers to provide high quality, sustainable FP information, counseling and services

- Improve the capacity of religious leaders and other community stakeholders to increase congregants' demand for FP
- Develop and disseminate a model for replication for strengthening family planning in other Christian Health Associations in other sub-Saharan African countries

During the project period, CHAK engaged religious leaders in mosques, churches and other community groups to educate, mobilize and create linkages and referral to health facilities for family planning services. Further, CHAK collaborated with religious leaders, CHVs and health facilities. The collaboration provided a forum where partners worked as a team to solve problems and generate new strategies to approach the community.

Notably, religious leaders joined this collaborative effort with varying levels of knowledge, although they present a great opportunity for sustainable scale-up of public health programs, particularly in Africa, in terms of improving knowledge, acceptance, utilization and promotion of family planning. Religious leaders command respect and trust in the community. They regularly have captive audiences and are very committed to the spiritual and physical wellbeing of individuals and families. Engaging with them assured the project of a continued decline in religion-related barriers to contraceptive use among their congregations. Through the project's training, the religious leaders became champions in the community and they reached an additional 12,352 people with family planning messages. The religious leaders further referred 2,438 clients to health facilities for FP services.

Training of religious leaders at Dophil Maternity & Nursing Home

Distribution of cycle beads to Health facilities by CHAK

Gender mainstreaming

Adolescent girls and teenage mothers, particularly in rural areas, experience reproductive health challenges due to lack of information on safe sex and pregnancy prevention. In addition, they are at risk of childhood marriage, early childbearing and teenage pregnancy, due to negative cultural practices and attitudes. These challenges have been exacerbated by a lack of education and life skills among girls. The result has been to disempower girls in male-female relations. As part of their contribution to the PWK project, FAWE Kenya sought to address the unique needs and challenges of adolescent girls by employing strategies that keep girls in school, develop their confidence and social skills, and provide them with life skills as provided in the Kenya reproductive health and life skills curriculum.

FAWE helped 40 teenage mothers re-enter school after dropping out once they became pregnant. Returning to school saves these girls from child marriages and may delay subsequent pregnancies. This was achieved through the teenage mother school reentry policy adopted by the Kenyan Ministry of Education.

FAWE organized a mentorship forum in April 2015 for 40 teenage mothers. During the forum, the girls were taught about pregnancy prevention, contraceptive use and life skills, including how to negotiate for safe sex and how to say no to premarital sex. In addition, 506 school-going girls were taught about HIV/AIDS and pregnancy prevention, which included dispelling common myths about contraception. In April 2015, FAWE Kenya also organized an SRHR sensitization meeting for 134 first-year female students at Masinde Muliro University to address their vulnerability to unwanted pregnancies and sexual abuse due to lack of information on pregnancy prevention and contraceptive use.

Building the confidence of girls and young women is also crucial in the prevention of early pregnancy and child marriage. FAWE Kenya used the ***Tuseme*** model: a theater for development technique that addresses the lack of confidence and empowerment among young women that prevents them from speaking out on issues that affect them, particularly issues related to sexual and reproductive health and rights. Through the model, 789 girls were trained in life skills and 40 life skills clubs were established in schools.

In addition, in November 2015, FAWE Kenya trained 35 students (22 males and 13 females) at Masinde Muliro University of Science and Technology, the majority of whom were first-year students. The aim was to create awareness about adolescent sexual and reproductive health. The students trained as ToTs to disseminate the information to other students in the university and outside, youths in the community, secondary school students and pupils in upper primary school. Through the training, the students were able to develop a work plan that would act as a guide in disseminating the knowledge and skills gained.

Finally, FAWE Kenya addressed girls' disempowerment by making communities aware of the importance of keeping girls in school as part of ASRHR. Parents and community leaders have been urged to take their girls to school and support them to remain in school and complete their education. Parents and teachers have been informed of girls' needs at schools, including the need for affordable sanitary towels and menstruation management. In this way, FAWE Kenya has illustrated how gender plays a critical role in the realization of sexual and reproductive health of adolescent girls.

Dissemination activities: conferences, county stakeholder meetings

The following key dissemination activities were conducted during Phase 2 of this project.

Participation in the International Conference on Family Planning (ICFP)

ICFP 2013: In November 2013, the project team participated in a panel presentation at the ICFP in Addis Ababa, Ethiopia. The presentation, titled: *Family Planning: It takes a health*

workforce, was organized by IntraHealth International, APHRC and Partners in Population and Development (PPD). The panel highlighted promising African initiatives in human resources for health (HRH) and reproductive health (RH), with potential implications for the areas of pre-service education, expanding the role of CHVs, and advocacy with national governments. The project team made a presentation on ***Community Health Volunteers' role in increasing access to family planning: Experience from a rural community-based distribution program*** in which they shared experiences from this project.

ICFP 2016: This conference, which was earlier scheduled to take place in November 2015, was postponed to January 25-28 2016. The project consortium organized an on-site auxiliary session at the ICFP conference in Nusa Dua, Indonesia. This session intended to create another platform for sharing lessons and experiences for improving contraceptive uptake at the community level. The project also presented the case for improving access to RH services among the youth and for the use of religious leaders to enhance FP acceptability and access.

This high-level panel session on ***Community-based Family Planning Services Delivery: Lessons, Challenges and Sustainability*** brought together leading global researchers and program implementers to share lessons and experiences for improving contraceptive uptake at community levels. Study findings from the project were presented as follows:

1. A Consortium Approach to Community Family Planning Service Delivery Program- ***Michael Mutua*** (APHRC)
2. The Impact of the Packard Western Kenya CBD Program in Busia and Siaya Counties in Western Kenya- ***Amos Simpano*** (FHOK)
3. Promoting Contraceptive Uptake among Young People Using Interactive Media, Peers and Youth Empowerment in Western Kenya- ***Jacob Ochieng*** (CSA)
4. Involving Religious Groups in Promoting Women's Health in Western Kenya: Opportunities and Challenges- ***Jane Kishoyian*** (CHAK)
5. The Packard Western Kenya Program achievements, challenges, lessons, best practices and conclusions- ***James Aringo*** (GLUK).

The presentations were followed by a panel discussion that aimed at providing varying perspectives on what works to address both demand and supply side challenges in family planning in the context of the global health. The panelists were:

1. Dr. Diene Keita, Representative- UNFPA, D.R. Congo
2. Dr. Shawn Malarcher- USAID, Washington D.C.
3. Dr. Jackson Kioko – Acting Director of Medical Services, Kenya Ministry of Health
4. Hon. Andrew Toboso (***Represented*** Hon. Wycliffe A. Oparanya, EGH- Governor, Kakamega County)

Presenters and panelists at the ICFP 2016 session on the Reversing the Stall in Fertility Decline in Western Kenya project session in Nusa Dua, Indonesia. Prof. Richard Muga of the Catholic University of Eastern Africa - Uzima University College, moderated this panel.

The consortium partners also, in collaboration with the Strengthening Evidence for Programming on Unintended Pregnancy (STEP UP) Consortium, organized another auxiliary session on "Adolescent Sexual and Reproductive Health: Lessons from the South". One of our consortium partners, CSA, presented on "Reversing the Stall of Fertility Decline in Kenya." The presentation further highlighted our work with both in-and out-of-school adolescents and youth in Western Kenya.

Ms Carol Gatura attending to a visitor at the joint PWK and STEP UP booth

Lastly, the project consortium, in collaboration with the STEP UP consortium, had an exhibition booth at the conference; program materials such as reports and articles were on display at the booth and attracted many visitors.

Participation in the Tropical Institute of Community Health (TICH)

(TICH) Annual Scientific Conference

During the project implementation period, the project consortium participated in the 10th, 11th and 12th TICH Annual Scientific Conferences. The pictures below depict the 2014 and 2015 TICH conferences where full plenary sessions were held on the project.

Participants at the Packard Western Kenya Panel at the 11th (left) and 12th (right) TICH Annual Scientific Conferences in April 2014 and 2015.

The conferences, which brought together researchers, policymakers, implementers and end-users of evidence from all over the world, created a platform for consortium partners to share the results, lessons learned, best practices, experiences and sustainability plans for the community-based family planning program. The sessions involved presentations and discussions on the consortium's approach to implementing a community-based family planning initiative and its impact. In every conference, the project sponsored participants who contributed towards session discussions and shared their experiences within the project. These participants included sub-county health management teams (SCHMT), facility in-charges, CHVs, CHEWs and national level MoH teams. CHVs used these forums to talk directly to address county health management teams on their role and needs in health systems strengthening.

Participation at the various county stakeholders' meetings held in Busia and Siaya counties

Between 2012 and 2015, 19 stakeholders' meetings were held, 10 in Siaya County and nine in Busia County. The meetings sought to share project achievements, lessons learned and best practices and to encourage other partners to adopt the project design so as to implement similar intervention projects. These meetings were attended by key stakeholders who are also involved in decision-making on policy changes in the public health sector, from the community to the county levels. These stakeholders included other RH partners, the County Minister of Health, the County Director of Health, the County Governor, the County First Lady and the County and Sub-County Health Management Teams. These meetings emphasized the role of community-based distribution in increasing contraceptive use in areas where health services were inaccessible and presented the consortium's approach to delivering FP services as the best way to reach these areas with limited resources, while avoiding duplication of efforts. In addition to these activities, courtesy calls to SCHMTs during joint visits by the Packard Foundation and the implementing partners gave partners an opportunity to discuss project activities with the county health teams and to understand the current priorities of the county governments.

Publications

In 2013, three papers using the baseline data were written and submitted for peer review. The three articles have been published as below.

1. *Benefits of family planning: an assessment of women's knowledge in rural Western Kenya*, published in BMJ Open[6]
2. *The Influence of Religion and Ethnicity on Family Planning Approval: A Case for Women in Rural Western Kenya,* published in the Journal of Religion and Health[7]
3. *Women's attitudes towards receiving family planning services from Community Health Volunteers in rural Western Kenya,* published in the African Health Sciences Journal[8]

[6]http://bmjopen.bmj.com/content/4/3/e004643.full
[7]http://aphrc.org/wp-content/uploads/2015/03/The-Influence-of-Religion-and-Ethnicity-on-Family-Planning-Approval-A-Case-for-Women-in-Rural-Western-Kenya.pdf
[8]http://www.bioline.org.br/pdf?hs15023

Three other articles based on the MIS data are currently under development. The baseline survey report was completed, printed and distributed in June 2014. The project teams continue to distribute copies of this report, both in print and electronically. In addition, one policy brief was written from this project, entitled *Family Planning Matters*[9]. A number of blogs were disseminated through partners' websites, and in print. The next phase of the project will also focus on writing journal articles and sharing project implementation strategies with as many partners and policymakers as possible.

Advocacy activities (county advocacy meetings, policy impacts recorded, county stakeholders' meetings, etc.)

Advocacy meetings in Siaya and Busia

In February 2014, the core project partners and collaborators held a county stakeholders' forum to lobby for increasing budgetary allocation to FP services to at least 5% of the health budget, and for stipends and NHIF registration for the CHVs in Busia and Siaya counties. The meeting created a platform that was used to share project achievements, lessons and the plans for the project's future, and to highlight the role of family planning in improving health outcomes.

The two advocacy meetings increased the attention, interest and commitment of government to FP issues in the counties. After the meeting, the two county governments allocated specific budget lines for FP. In Siaya County, the County Government allocated Ksh 2,000,000 (US$. 20,000) of the total County health budget to family planning. The same County Government included CHVs in the County Government budget allocation, from which each receives a monthly stipend of Ksh. 2,000 (US$. 20). The CHVs can now access medical care using NHIF cover, which is provided by the County Government. CHVs also have mobile phones to aid in tracking and streamlining referrals from the community to the health facilities through the CHVs.

In Busia County, the County Government allocated similar resources in the 2015/2016 financial year's budget allocations to initiate income-generating activities for the CHVs. They have already factored placement of CHVs on monthly stipends in the 2016/2017 financial year budget. In July 2015, Busia County, through the County Governor, launched an FP/RH strategic plan sponsored by CSA.

On May 16, 2015, the FAWE Kenya Board of Governors paid a courtesy call to the County Director of Education (CDE) and the Teachers Service Commission (TSC) County Director in Busia. The meeting was a vehicle to advocate for the integration of ASRHR into the nationwide school curriculum and to consolidate their support for the implementation of ASRHR project in schools across western Kenya. These inputs are under consideration in the development of the ASRHR curriculum by the Kenya Institute of Curriculum Development (KICD).

CSA organized four stakeholders' meetings with the health and education ministries in Busia and Siaya counties, and attended stakeholders' meetings organized by partners in both counties.

[9]http://aphrc.org/publications/family-planning-matters/

Advocacy meetings in Bungoma, Kakamega and Homabay counties

The success of the project design and implementation attracted interest from other counties and an expressed desire for the partners to roll out similar activities in Bungoma, Kakamega and Homabay counties. In July 2015, APHRC and its collaborators held advocacy meetings in those counties, sharing achievements and lessons learned from the implementation of the six-year PWK Project in Busia and Siaya, and to hold further discussions on the consortium's intention to initiate a a similar intervention to respond to the identical challenges of poor access to contraceptive commodities, high fertility rates, high unmet need for FP and poor maternal and child health outcomes. The teams were supportive of the idea, and committed to encourage the partners to implement family planning interventions in their counties. This was part of the application process for the County Innovation Challenge Fund grant, which, if awarded, would replicate the Busia and Siaya activities in Bungoma, Kakamega and Homabay.

The Deputy Governor of Busia County giving a talk at the Busia County advocacy forum in February 2014.

World Contraceptive Day celebrations

The consortium of partners participated in World Contraception Day celebrations, which were held annually on September 26.

The consortium partners pooled resources with other RH partners to co-finance these events, held in both Busia and Siaya counties, and make them a success. The events were used to

make women aware of the importance of family planning and the provision of services, and to encourage communities to reject myths and misconceptions about various FP methods. This was achieved through among other things, theater skits, and speeches by key opinion leaders in the communities, as well as through actual counseling session.

Other achievements

Systems development and strengthening

a) Built and sustained a critical mass of quality CHVs

The project recruited and trained 600 CHVs to carry out community-based distribution of contraceptives. Throughout the project period, the consortium partners sustained all CHVs through a monthly stipend up to the end of Phase 2 activities in May 2015. The CHVs were well-equipped with knowledge and skills and were continuing with FP CBD and other health services at the county level. CHVs now support government work as well as consortium and individual partner-organizations and project activities. The trained service providers from the Ministry of Health were also equipped with knowledge and skills for the continuous provision of LAPM. The project also supported quarterly data review meetings, county health stakeholders' meetings, purchasing and training on commodity management, and engaging the Ministry of Health on joint quality assurance as part of strengthening the health system.

b) Implemented community strategy

In Siaya County, the project triggered full implementation of the community strategy, which resulted in a county-wide training for all CHVs on the basic module. It also led to training of CHEWs who are now closely engaged in supervising CHVs for continuation. These engagements have nurtured improved relationships among clients.

c) Established Bondo Youth Friendly Services Centre, Siaya County

After continued lobbying between the project implementing team and the Siaya CHMT, the Siaya County Ministry of Health approached FHOK to establish a youth-friendly services center within Bondo District Hospital. This led to the renovation of a disused structure, which later became an active YFS provider in the sub-county, reaching out to young people with information and services.

d) Revived data quality audit meetings

The project supported data quality audits in Busia and Siaya counties to harmonize partners' data with data in the MoH's Health Information System. This meeting triggered more data quality audit check-ins to monitor core RH indicators reported through the counties' HMIS. Other partners have adopted this system to harmonize their data.

e) Strengthened community structures

The CBD program strengthened community structures involved in the management and governance of the health sector at the lowest levels. CHVs and CHEWs are members of the Health Facility Management Committee: a unit involved in health system governance. The CBD program empowered CHVs/CHEWs, through community dialogue and feedback forums, to

use the Community-Based Health Information (CBHI) data to develop annual facility operation plans that are reflective of health needs and priorities identified by the community. Further, the community resource persons involved in the CBD program use CBHI to address common barriers to the use of family planning and to monitor the allocation and utilization of devolved health sector funds. These contributions have cumulatively led to increased ownership and participation by communities in the delivery and utilization of health services, particularly FP.

Partnership and relations among consortium partners and other partners

a) Leveraged resources

Together the project consortium partners teamed up with other RH partners to co-finance various health initiatives and collaborated with the Ministry of Health to conduct training for service providers and CHVs. Partnering with other actors in the reproductive health space, they co-financed the activities of World Contraception Day in 2013, 2014 and 2015, the activities of World Breastfeeding Week in 2013, training on commodity management, and hosting RH stakeholders' forums, partners' quarterly review meetings and county advocacy meetings. The project also collaborated with other FP partners to solicit commodities: pills and condoms from PSI Kenya, for example, for distribution during stock-outs. The consortium partners shared IEC materials with other stakeholders outside the consortium. During outreach and training activities, consortium service providers and training facilitators, shared training centers, and provided referrals for services to other stakeholder facilities. This strengthened partnership with other actors in the region while cutting implementation costs to all partners.

b) Established partnership and cooperation with other organizations

The relationship of the project consortium partners with other organizations improved over time and on different fronts. The partners identified strategic areas to complement one another's efforts, which served to strengthen each individual partner's image, visibility and profile in the intervention areas. The project also established partnerships and cooperation with other organizations and institutions, including CHMT, county administrators and County and National Divisions of RH (DRH/DCHS), as well as other stakeholders in the counties and at national level.

c) Increased attention to family planning

Working together with the county governments, the project increased the attention, interest and commitment of county governments to FP in the counties. The two county governments have developed an interest in FP issues, which has been demonstrated through budget allocation for FP commodities and services by the governments. The project advocated for the inclusion of CHVs within the county health systems, which led to the enrolment of CHVs in the NHIF scheme and the provision of monthly stipends. The program also identified and registered 10 new households with the NHIF; these household members can now access FP services using their NHIF medical cover.

d) Collaborative learning and skills transfer between consortium and collaborators

The consortium partners were able to learn from each other to improve on their performance; for example, FHOK moved their long-term FP services from central district health facilities and main clinics to peripheral/lower level health facilities. This was a strategy initially adopted by MSK and helped FHOK to improve their numbers on uptake of permanent contraceptive methods. FHOK also improved their performance on LARCs through the establishment of an independent outreach team, a strategy that they borrowed from their MSK partners.

e) Inspired roll-out process in other counties

The success of the project design and implementation, as disseminated in stakeholders' meetings and at conferences and workshops, stimulated interest from other counties, which has triggered demand for a roll-out of this project's activities to Bungoma, Kakamega and Homabay counties. For instance, Bungoma county, with support of CSA and other partners, has launched an initiative to raise funds in support of family planning in the county.

f) Contributed towards curriculum development

Project CHVs in Siaya County were used to pre-test the revised national CBD curriculum, which has now been approved and rolled out nationally. This curriculum is currently being used to train CHVs. School health programs and the community health strategy strengthened the partnership between schools and health facilities, which led to a reduction in the number of girls dropping out of school completely, by increasing the school re-entry rate of these girls after becoming pregnant.

g) Established Busia County Technical Working Group

In October 2015, CSA, in collaboration with the Busia County Ministry of Health, held an FP Technical Working Group (TWG) advocacy training meeting that brought together all PWK partners and other FP stakeholders, including APHRC, NCPD and IPAS, among others, to form a TWG team. The goal of the TWG was to ensure that Busia County's RH strategy was implemented and to monitor its trajectory toward intended outcomes. The main objective of this exercise was to ensure that Busia TWG reached consensus on the mandate and goal of the TWG. Members of the county TWG learned how to apply the AFP SMART approach and developed an advocacy work plan on identified key priorities, outlining ways to leverage resources for implementation of the RH/FP strategy. The two-day session led to the identification of key priority issues regarding RH/FP that the team would spearhead to the end, including their advocacy role.

h) Sponsored joint support supervision of the CHVs by the counties and the Ministry of Health

The project sponsored MoH personnel to join the county in supervising activities at health facilities. On a quarterly basis, FHOK and MSK sponsored county and sub-county health management teams to supervise activities at the health facilities, including those offered by all PWK partners. The project also sponsored the quality assessment by the team from the MoH division of family planning of PWK activities in Busia and Siaya Counties, including activities by the Community Health Volunteers and facility-based FP service provision, to ensure the activities conformed to set standards and were implemented within the community strategy.

CHAPTER 4

MAJOR IMPLEMENTATION CHALLENGES AND CONSTRAINTS

MAJOR IMPLEMENTATION CHALLENGES AND CONSTRAINTS FACED

This complex project was certainly not without challenges. The following challenges hampered achievement of some of the project objectives:

- Competing priorities between programs, between government and programs and among the government's and other stakeholders' priorities interrupted the continuity of program activities.
- Limited capacity of CHVs: The majority of CHVs have basic education, and it is costly and time-consuming to make them advocates of change. This affected the quality of reports as well as data collection and collation. A current proposal to the Ministry of Health is to formulate criteria for the choice of CHVs (such as age limits, candidate's level of education and whether the candidate is a role model).
- The use of the same CHVs by different programs/projects created challenges. CHVs constantly overwhelmed by many functions, lost focus. Data collection, too, tended to overwhelm the CHVs.
- Emerging concerns that are not scientifically proven, such as fears of high contraceptive failure among HIV-infected women who are on active anti-retroviral treatment/therapy (ART) only increased the number of myths and misconceptions about contraceptives in the process of implementation. This served to erode the hard-earned gains in dispelling of the barriers to the adoption of modern contraceptive methods.
- High levels of stigmatization of family planning and other SRH services in the project regions hindered greater penetration of FP services among community members.
- There was evidence of lack of respect for the opinions of young people and most of their suggestions and contributions to the FP discussions were never taken seriously at the community level.
- The supply of FP commodities was erratic due to the lack of prioritization of FP services by the devolved governments. Partners were forced to conduct training on FP commodity management for service providers in order to streamline consumption and requests, and they lobbied for enough resource allocation for commodities.
- There was high staff turnover over during the project period. The frequent transfer of service providers who had been trained on LAPM within this project created a skill gap and made it difficult to provide uninterrupted services.
- Service providers are overwhelmed with responsibilities and any additional programs/projects only burden them further.
- There was a high prevalence of myths and misconceptions about some types of contraceptives, especially IUCD and vasectomy. The project rebranded method bags as magic to make women aware of various types of FP methods and conducted proper

counseling about all FP methods to reduce the effects of these myths. These method bags provided IEC materials that made it easy for rural women to understand how different family planning methods works.

- Strong cultural and religious biases against contraception were evident. Future programs should identify and work closely with influential stakeholders, for example, religious, political and community leaders, CHVs and men as the heads of households, from the outset of a project.
- Cases of lack of facility reports due to improper documentation were also noted during implementation of this project. The project coordinators requested the county governments' health management teams to streamline data capture at health facilities and further support them by training service providers on data management, and to support supervision by the Sub County Health Records and Information Officers through regular data quality audits and quarterly review meetings.
- The 2013 transition from national health management to county health management as healthcare functions were devolved to county governments. This brought in new priorities set by the counties, rather than the priorities previously set by the national MoH.
- Well-trained and experienced youth PALS aged-out of the program.
- The mobility of youth within youth groups posed a challenge to program implementation too. These dynamics included dropout due to marriage, death and migration (for jobs in far-off areas).
- It was difficult to engage students and teachers in ASRHR sensitization campaigns as curricular events were prioritized above any non-examinable activities.
- Due to cost constraints, the duration of the peer educators' training was shortened from five days to two days and this led to rushed training, which threatened the participants' ability to adequately master and internalize the content.
- There was resistance by the community, including teachers, towards ASRHR as it focuses on sexuality, which is considered a taboo subject in the culture and traditions of some communities.
- Facilities that offered youth-friendly services were few and far apart within the project areas, and this led to incomplete referrals due to geographical barriers and the attendant out-of-pocket costs necessary to reach these facilities such as bus fare.
- There was a lack of support structures to help teenage mothers re-integrate into school and to allow them to care for their children.
- The achievement of ASRHR project objectives was challenged by the misconception held by men and boys that ASRHR was a challenge unique to girls.
- There were occasions when project plans conflicted with unforeseen government planning, such as the various polio campaigns conducted during the project period, where all other activities in the counties were suspended as everyone focused on the polio campaigns.

CHAPTER 5
LESSONS LEARNED AND AREAS OF IMPROVEMENT

LESSONS LEARNED AND AREAS OF IMPROVEMENT

Outcome 1: Increased provision of family planning services at community level

- Training service providers on commodity management improved the use of quality data and this was achieved at minimal cost by using this project's consortium approach. This helped in reducing stock-outs through the tracking of commodities. The continuous provision of commodities through CHVs and allowing CHVs to take charge of stock replenishment made it easier to implement FP programs.
- The program partners resolved to embrace economic order quantity[10] to avoid gaps or excesses in any facilities - this was a modified pull system based on need at specific times.
- The use of CHVs helped to cover a wider area. When incorporated with referral, it narrowed service delivery to a smaller area for more effective reach.
- Combining community distribution and referral systems created demand, provided services, and allowed for referral where necessary. Supporting community-level structures is likely to achieve more sustainable impact. The community approach also fostered ownership of program activities by the community or local administration.
- A consortium approach built a stronger push for policy change. Direct contact with the community as a consortium built a stronger case for policy improvement. We invoked community engagement in policy development and influence. This consortium approach was also a more effective way to avoid duplication in program implementation efforts. Combined with clear definition of roles and availability of resources, the success of such a program is more sustainable. The religious leaders were key in FP advocacy and can be useful in dispelling myths about FP in future. Personal testimonies from permanent method users (of both BTL and vasectomy) can also be used to encourage people to use contraceptive methods and help in reducing myths and misconceptions about various FP methods.
- Future programs should invest in building the foundation, support structures and systems of community health strategy though training and mentorship of CHVs and service providers and provision of equipment, and support supervision for the success of the project.
- Improve recruitment and training of CHVs. Better-trained CHV were able to compile better reports on service provision. Recruitment should be based not only on popularity, but also

[10]Economic Order Quantity is a modified pull system: Partners conducted facility visits to identify stocked out commodities at these facilities, as well as overstocked stocked facilities, based on an analysis of the facility's commodity-specific demand. The partners then would obtain these commodities from the over-stocked facilities and redistributed them to the stocked out facilities. They also obtained commodities from other stakeholders among them Population Services Kenya, Partner clinics such as FHOK clinics and MSK's Amua clinics and resupplied to the facilities were stocked out or near their re-order level.

on the candidates' ability to serve as CHVs. Improving the capacity of CHVs built a case for governments to invest more resources in training.

- Having peers from the community improved the level of interaction and delivered services closer to the users. Peers communicated much better and reached community members, especially youth, more easily. The dialogues generated here were key to fueling demand for family planning.
- Integrating family planning with other services, such as cervical cancer screening, improved the uptake of services and reduced the risk of missed opportunities in service delivery. The project established the need to offer these services under one roof, preferably in the same room.
- The program expanded the base of CHEWs available to supervise both CHVs and PALs. The CHEWs also supported SRH activities in schools.
- The consortium established that training CHVs and improving their capacity also improved the quality of data and information that programs fed back to the community. These CHVs were able to relate better with the community and demystify FP methods, which generated more demand for services
- Proper sensitization and involvement of key stakeholders at all levels and aligning project activities to existing government strategies and policies enabled full participation and ownership of the intervention programs. This facilitated easy penetration and quick ownership of project activities by the county governments and communities, leading to more sustainable projects.

Outcome 2: Improved capacity of health providers to provide FP/RH services

- Working with, and supporting and strengthening, government structures improved service delivery. As compared to mobile clinics, working with government service providers who acted as trainers of trainers (ToTs) further increased the number of trained service providers. Using the existing government structures can mitigate some of the effects of rapid staff turnover by ensuring a pool of trained personnel who can provide services at all times. The project developed a mentorship program to achieve this end.
- The project worked to improve the capacity of service providers to offer LAPM and that of CHVs to provide counseling services and short-acting FP methods.
- The project proposed the creation of skills laboratories to provide continuous knowledge to a bigger pool of service providers. This would involve strengthening continuous medical education (CME) programs and restructuring them to handle staff transfers.
- The project created an avenue for direct engagement between the providers and the community, which has greatly improved both the quality of care and data capture.

Outcome 3: Improved demand for FP services through effective outreach activities and distribution of IEC materials

- Outreach activities served to eliminate three major levels of delays in FP services:

a) Delays in decision-making—reduced through IEC, the distribution of facility contacts and the use of a Facebook page and other social media resources;

b) Delays in reaching services: resolved by using outreach services to bring services as close as possible to clients

- Delays in obtaining care: reduced by training more care providers. Services were also provided at times more convenient for the clients. Some clients attended outreach activities after working hours and this increased method uptake compared to relying on provision during normal facility operating hours.
- The use of diversified approaches that were community friendly, such as drama and youth activities, catalyzed behavior change and hence increased demand.
- Community theater was useful in promoting FP and in conferring to youth additional social benefits. The use of the Magnet Theater Group and edutainment techniques was effective in reaching men in public places and those in informal employment, such as those working in the transport service industry, with messages about FP. The approach also effectively passed FP messages on to both out-of-school and in-school youth. The edutainment communication technique was useful in dispelling FP-related myths and misconceptions commonly held by men and therefore helped men to structure, initiate, and prompt discussions about FP with their spouses. Future interventions need to consider these types of approaches.
- The participation of beneficiaries, particularly in the development of IEC materials, should be emphasized in future as they are the best means of communicating with peers. FAWE Kenya involved youth in the development of IEC materials targeting their peers. This led to the development of highly effective and targeted IEC materials that addressed the issues affecting them. In addition, beneficiary statements and theater/drama provided a platform for beneficiaries, acting as role models for their peers, to share their experiences and explain how ASRHR training and other ASRHR project initiatives had positively affected their lives. This also drew the interest of other students to SRH issues and increased membership of ASRHR school clubs.
- As part of participatory programming, male counterparts should also be involved in ASRHR activities. Their participation was inadequate and most partners' main focus was on girls and women. During the implementation of the project it was realized that men held various myths and misconceptions that contributed to the problems of unwanted pregnancies, early marriage and other reproductive health challenges. Therefore, including the interests of men in ASRHR is paramount in addressing reproductive health challenges affecting women and girls.

- Providing a platform for the whole community to participate in RH matters made a significant impact on the target beneficiaries. The project included community networks and systems and community leaders as well as local media and communication channels to create awareness about SRH and ASRHR. This led to improved support for youth in accessing reproductive health services. However, more effort needs to be put into using these channels to speed up the uptake of ASRHR and investing in more community systems.
- Working with CHVs proved to be an effective way to reach more people with information, especially through door-to-door channels.
- Once equipped with skills, teachers were an important group in promoting SRH among youth in school.

Outcome 4: Improved social and policy environment for FP services through program monitoring activities and disseminations

- The diversity of capacity within the consortium increased its ability to engage with government and other stakeholders and to accelerate implementation of policies like the school re-entry policy for girls.
- The use of effective, sustained and strategic engagements with different levels of stakeholders increased the uptake of services. CHVs are now more motivated to work due to government support. The program also set the tone for how government or other stakeholders engage with CHVs.
- The project demonstrated the value of working together as a consortium as compared to working as individual organizations. It increased the pressure on stakeholders and partners alike to deliver results and show them through documentation. Partners were also influenced to create the changes that many stakeholders expected.
- This project proved that a consortium approach is more cost-effective, and created a more accountable use of donor resources by all partners.
- The project led to improved client-health worker relationships as clients who were referred to health facilities by the CHVs received quicker attention and better services. This was due to the improved relationship and smooth collaboration between service providers and CHVs.
- The school calendar affected project implementation and should be considered at all times. It was important to get the buy-in of head teachers and even to link ASRHR messages to particular academic events in order to have them included in the main school activities. In addition, the use of routine school forums such as school assemblies, as in FAWE's case in Uganda, increased the avenues for reaching out to in-school youth with ASRHR.
- An understanding and appreciation of ASRHR by teachers and students improved the learning environment and, consequently, learning outcomes. This was witnessed in Uganda

in FAWE's intervention programs, where beneficiaries of the ASRHR project excelled in the National Certificate Examinations. Therefore training of teachers on ASRHR should continue.

- Partnerships are strategic at both national and grassroots levels. Partnerships should be forged to address ASRHR in national policies and plans. At community level, partnerships with like-minded organizations as well as community networks are essential in providing comprehensive support to beneficiaries. As was noted in Kenya, both grassroots NGOs and women's groups would be invaluable in addressing the challenges faced in enforcing the school re-entry policy for teenage mothers.
- The involvement of government authorities is also fundamental in achieving project objectives. Their involvement legitimized FAWE's cause and eased the acceptance at community level. In Kenya, support for ASRHR was obtained from teachers and school administration because of authorization from MoH officials. Further engagement of the TSC will facilitate the increased and active involvement of County officials, thus trickling RH services down to school activities at the county level.
- A rights-based programming approach (RBA) should be embraced, as it will make participation, non-discrimination and equality some of the basic tenets in achieving project objectives. Duty bearers and rights holders should be equally involved in project activities as they outline roles and responsibilities of each stakeholder. In Kenya, the need to reach out to girls with disabilities is increasing as they face similar challenges.
- Working as a consortium strengthened the relationship between partners, though constant engagement, learning and sharing experiences. This partnership has continues to explore new opportunities of working together and keeping the working relationship between partners.

CHAPTER 6
BEST PRACTICES

BEST PRACTICES

Rolling out FP (BTL) outreach activities from central district health facilities to peripheral health facilities

The fast, efficient delivery of BTL services in a client-focused manner, including offering services at the nearest point to the client, was the best innovation that the implementing partners (MSK and FHOK) brought to the project. In most health facilities in Western Kenya, clients had been required to wait for weeks before they could receive a service. Specifically, MSK revolutionized the way BTL services were offered to by reducing the waiting period to, at most, 20 minutes. In the PWK, BTL services were provided by MSK's mobile outreach teams, each of which comprises a surgeon, nurse, nurse aid and driver. These mobile teams relied heavily on CHVs to mobilize and create demand for FP services in the community. The teams also used the existing infrastructure at health facilities, including the nurses, reproductive health staff, supplies, equipment and space, among other things. It was this strategy, borrowed from MSK by FHOK, that saw a tremendous improvement in the number of clients accessing BTL services in Siaya County.

Stakeholder involvement

The PWK Project was implemented in collaboration with the Ministry of Health at both the national government and the county government levels. The consortium of partners involved the MoH at all levels, including sensitization meetings, the recruitment and training of CHVs, the supply of FP commodities for distribution, participation in outreaches, quality assessment exercises, support supervision and stakeholders' meetings, among other activities, and the joint implementation of National Health days and events such as World Contraception Day celebrations and World Breastfeeding Week. This was done with the support of both the County Health Management Team and Sub-County Health Management Teams in both counties. The teams were involved in and supported supervisory visits to health facilities, CBD follow-up and outreach activities. Working closely with the MoH and county officials improved reception and ownership of the project by community members. Whenever the project team had meetings with the community they engaged county officials and staff from the Ministry to give talks, and this has led to better reception by community members.

The engagement of religious leaders from multiple denominations by CHAK was fundamental to the project's success. Enlisting the support of clergy from Catholic, Protestant and Muslim congregations to promote a more positive approach to family planning made it easier to reach religious communities with FP information and services.

Consortium approach

The consortium partners agree that the consortium approach is the best way to achieve a variety of objectives with limited resources. The consortium brought together partners with a

diverse set of skills and expertise across implementation, advocacy monitoring and evaluation of family planning/contraceptive programs. As a consortium, partners were able to learn from each other in order to improve their performance and approaches. For instance, FHOK adopted MSK's strategy of rolling out outreach for LAPM to peripheral as a way of improving uptake of LAPM. In addition, FHOK borrowed the mini laparotomy method of BTL from MSK to improve their BTL service delivery in Siaya.

Decentralization

Community-based distribution of FP services was found to be a better approach to decentralizing activities -- reducing the workload at health facilities and increasing access to FP services -- than the traditional facility-based service delivery. CHVs were able to decongest various health facilities by providing door-to-door FP services. This approach was also lauded for its ability to both generate demand, through IEC materials distribution and communication, and service demand, through product delivery and referral for longer-acting methods.

The project also conducted mobile outreach from central health facilities to peripheral health facilities, thus reducing the workload in central facilities and allowing many clients to access FP services like permanent contraceptive methods without traveling long distances.

Successful coordination of the consortium

For successful coordination of the project activities, APHRC and its partners designed an implementation model with a clear set of distinct roles and responsibilities to guide ways of working together. These partners had strengths in different areas and were able to complement each other's efforts. On a quarterly basis, APHRC organized progress reviews and update meetings where partners would come together to share their achievements, challenges, planned activities and the way forward. Partners were able to share their work plans across the consortium. Using these work plans, partners could identify activities through which they could complement each other's efforts without duplicating roles. APHRC also pulled reports together and shared learning and ideas to help improve their performance. During the implementation, and as part of the learning process in the consortium, partners realized that having a trained doctor as a co-opted member of an outreach team was of benefit to clients, giving them a larger choice of family planning methods. Furthermore, establishing an independent outreach team rather than relying heavily on MoH service providers was best for improving access of FP services.

Male involvement

Community health units with male CHVs performed relatively well in promoting FP among men. Field reports indicated that male CHVs were able to relate better with male clients or potential clients and to address myths and misconceptions commonly held by men. It was evident that in Busia, male CHVs were able to mobilize men to access vasectomy, unlike in Siaya. The majority of men who took up vasectomy in Busia had been mobilized by male CHVs. Moving outreaches

from the central district health facilities to peripheral health facilities increased uptake of these services. BTL uptake, for example, increased in both Siaya and Busia counties.

Service integration

The integration of services also achieved good results. The project integrated cervical cancer screening into outreach services and this increased IUD uptake. The project also integrated HIV and FP through the provision of condoms as a dual protection method. The consortium believes that integrated provision of care will be more attractive to county governments.

Projects that target people with disabilities are also key to a majority of the county governments and national government as well; therefore a service integration that can also improve service provision to people with disabilities would be essential.

CHAPTER 7
PROGRAM AND POLICY IMPLICATIONS

PROGRAM AND POLICY IMPLICATIONS

- Advocacy for county government resource allocation to FP/RH services is continuing, so as to ensure family planning is embraced as an important strategy for developing healthy communities and the achievement of a county's own short- and long-term goals. There is also a need to expressly and boldly emplace FP services in overall county budgets
- The integration of sexuality education in schools is an ongoing discussion. To enhance its voice, FAWE has joined ongoing advocacy initiatives with like-minded organizations. The next phase of this project will emphasize government uptake of these FP/RH services and continued support for ongoing activities.
- There is a need for further engagement to ensure that ASRHR and the family planning agenda are integrated as outlined in the Siaya County RH strategic plan developed last year.

CHAPTER 8
SUSTAINABILITY STRATEGY

SUSTAINABILITY STRATEGY

- The consortium partners conducted refresher courses and mentorship for the MoH service providers and built a strong network of CHV for continuous demand generation and service provision on family planning. The project integrated its activities into existing government structures like the community strategy, which has structures in place that would easily enable continuation of the CBD project even beyond the funding period.
- Continuous mentorship for family planning updates was recommended to mitigate the common challenge of staff attrition.
- The partners lobbied for stipends and NHIF registration for the CHVs, which succeeded in Siaya County. The partners also lobbied for county governments to increase budget allocation to FP services to at least 5% of the health budget.
- The partners proposed the development of a skills lab to ensure continuous updates and training sessions for a well-trained workforce to take up FP service delivery in the event of staff transfers, departures or other changes. The project also lobbied for the establishment of as many youth-friendly centers as possible, as well as the establishment of well-equipped and well-integrated services to handle ASRHR services.
- The third phase of the project will lobby to establish FP/BTL and vasectomy calendar dates (i.e., clinics) at health facilities that will be advertised to the public.
- The project strengthened the capacity of CHEWs as supervisors of CHVs to monitor, supervise and evaluate CHV's work.
- The project focused on strengthening and integrating the project's activities with other partner activities, within and outside of the consortium, to ensure the continuity of project activities. The project has so far linked CHVs with private health sector players for referrals, for example, MSK's Amua clinics, to expand access to and support of CHV activities.
- Consortium members joined a number of dissemination meetings to share project achievements, lessons learned and best practices that other partners can adopt in rolling out CBD projects in other areas. Documentation is ongoing, in order to share with the rest of the community some of the best practices that may be replicated in similar areas that are still grappling with poor RH indicators.
- The project strengthened health structures and systems through the revival of district health stakeholder forums and data quality audit meetings, which are now routinely used by the MoH to check and harmonize partner and ministry activities and data.
- Holding trainer of trainers' sessions has been a major sustainability strategy to keep ASRHR messages consistent and ongoing. Peer-to-peer educators are another sustainable resource, as the knowledge in the school clubs focuses on key ASRHR messages.
- Close consultation with the CHMTs and use of the HIS helped to include data capture for RH service delivery, especially to young people, and this can eventually facilitate impact evaluation.

- There is a need to continue strengthening school health programs to increase knowledge and the quality of care, which in turn strengthens partnerships for ASRHR.
- Further engagement is needed in order to strengthen partnerships through the TWGs that were set up at the sub-county level during the sensitization forum in 2014.
- Further advocacy is recommended to implement the ASRHR and contraception agenda as outlined in the Siaya County RH strategic plan developed last year.

CHAPTER 9

CONCLUSIONS

RECOMMENDATIONS

NEXT STEPS IN REVERSING THE STALL IN FERTILITY DECLINE IN WESTERN KENYA

REFERENCES

APPENDIX

CONCLUSION AND WAY FORWARD (FUTURE PLANS, PROGRAM RECOMMENDATIONS, ETC.)

- CBD of FP is the best intervention in areas where health services are inaccessible; the approach fosters reproductive health behavior change where contraceptive use is low.
- CBD of family planning services is key in driving contraceptive use by both recruiting new users as well as retaining existing users of FP.
- It is possible to integrate FP service provision with other community-level health services such as distribution of bed nets water purifiers, etc.
- Religious leaders can use their community influence for good if their support for family planning is solicited and they are trained on how to address their congregations about the issue. They can also undermine existing efforts if they are not well-trained. They are therefore a must-address group of community gatekeepers.
- The consortium approach to delivering FP services may be the best way to achieve these objectives while using limited resources and avoiding duplication of efforts. This approach can be used to implement other interventions with limited resources.
- A more inclusive engagement with health and education stakeholders and development of targeted strategies for including ASRHR in the academic sphere will determine whether schools consider it an important agenda that requires attention.

RECOMMENDATIONS

- This consortium approach should be extended to other counties that continue to struggle with high fertility rates and low CPR due to poor access to contraceptives and lack of knowledge about family planning.
- All FP/RH stakeholders should continue to lobby for the allocation of county funds to support FP, through a costed FP strategy, to sustain gains comparable to what has been recorded in Busia and Siaya counties.
- Other stakeholders should be encouraged to take up CBD strategies in other interventions, conduct support supervision of CHVs and facility staff to ensure commitment, and provide stipends to CHVs to motivate them.
- Future project activities should take into account people with disabilities and gender mainstreaming. Under the PWK Project, FAWE worked with school heads and administrations to ensure that the school environment was suitable for both boys and girls, while also working to create an environment more conducive to the girl child's learning experience.

THE NEXT STEPS IN REVERSING THE STALL IN FERTILITY DECLINE IN WESTERN KENYA

The consortium was recently awarded an extension grant by the David and Lucile Packard Foundation to identify and expand the sustainability of key project interventions for an additional 18 months. The consortium partners identified certain interventions that they strongly believed were high-impact, with the potential of a short turn-around time (less than 18 months).

Broadly, this third phase of the project aims to support research, documentation, dissemination, advocacy and policy engagement activities as well as the institutionalization of key project achievements. Special attention will be given to dissemination of project achievements over the past six years of implementation. The consortium partners will also focus on addressing new research questions that emerged from the full implementation period, foster uptake of evidence and support institutionalization and sustainability of key program achievements. Small-scale implementation of key activities will ensure a smooth transition from project partners to the county governments, to ensure continuity of this project's achievements.

REFERENCES

1. Kenya National Bureau of Statistics (KNBS) and ICF Macro, *Kenya Demographic and Health Survey 2008-09.* 2010, KNBS and ICF Macro: Calverton, Maryland.
2. Kenya National Bureau of Statistics (KNBS) and The DHS Program, *Kenya Demographic and Health Survey 2014: Key Indicators.* 2014, ICF International.

Appendix 1: Indicator Summary Report

Grantee: African Population and Health Research Center, Inc.

Project Title: Reversing the Stall in Fertility Decline in Western Kenya: Expansion Phase

Grant No: 2012-38124

Project Duration: 36 Months

Project Start Date: November 2012

Project End Date: November 2015

Description: To continue the collaborative program to improve contraceptive prevalence rates in Western Kenya.

Reporting Period: (November 2012–August 2015)

Outcomes and Indicators Table (Table 2)

Outcome 1: Use of FP and improved FP/RH practices

Indicator	Description	Baseline in 2012	Projected result2015	Progress as at August 2015
1.1	Percentage of women aged 15–49 who report using a modern method of FP, by 8 percentage points	Busia = 36.2 Siaya = 37.8	Busia = 44.2 Siaya = 45.8	57 51
1.2	Increase in contraceptive prevalence rate among married women aged 15–24 with 0–2 children, by 7 percentage points	Busia = 27.0 Siaya = 38.4	Busia = 34.0 Siaya = 45.4	TBD TBD
Comment	Status: The KDHS 2014 indicated a great improved on contraceptive prevalence rate estimates. The figures for indicator 1.1 are purely from the recently released KDHS 2014.			

Outcome 2: Improved capacity of health providers to provide FP/RH

Indicator	Description	Baseline 2012	Projected result 2015	Progress as at August 2015
2.1	Number of CHVs trained on the FP technical module, counseling and provision of pills and condoms	Busia = 187 Siaya = 187	Busia = 275 Siaya=350	Busia = 275 Siaya = 325
2.2	Number of service providers (public and private) trained on provision of long-acting reversible and permanent methods of FP and delivery of integrated RH services	Busia = 10 Siaya = 14	Busia = 20 Siaya = 30	Busia = 90 Siaya = 73
2.3	Number of clients referred and served with long-acting and permanent methods of FP in the collaborative private facilities per month (30 clients per month per county)	Busia = 0 Siaya = 0[11]	Busia = 600 Siaya = 600	Busia = 12,412 Siaya = 11256
Comment	2.1. 600 CHVs (275 in Busia and 325 in Siaya) received initial and refresher training on the FP technical module and counseling on and provision of short-acting contraceptive methods and were involved in distribution of pills and condoms and referrals for LAPM. 2.2. 163 service providers were trained on CTU and commodity management skills. In Busia, 90 service providers (80 public and 10 private) underwent contraceptive technology up-dates and commodity management skills trainings. In Siaya, 73 service providers 70 nurses and 3 medical officers), all from public facilities, were taken through the training and mentorship program on LARC and permanent methods (BTL and vasectomy). Private providers were trained by AMUA clinics (MSK private clinics funded by a different donor in Siaya). 2.3. The numbers indicated above are total successful referrals from both private and public health facilities. All successful referrals refer to facility and outreaches referral, with no separation between public and private facilities.			

[11]There were clients but they were not properly captured in the reporting system.

Outcome 3: Improved supply and access of FP services

Indicator	Description	Baseline 2012	Projected result 2015	Progress as at August 2015
3.1	The number of acceptors of FP new to the CBD program served by community-based distribution, through outreach referral to nearby clinics and through CBD by method per month (In Busia, 2,040 acceptors per month; in Siaya, 2,520 per month)	Busia = 0 Siaya = 0	Busia = 40,800 Siaya = 50,400[12]	Busia = 72,570 Siaya = 74,233
3.2	Number of acceptors new to modern contraception (new users) served by community-based distribution, through outreach and through referral to nearby clinics (In Busia, 570; In Siaya, 700 new acceptors per month)	Busia = 0 Siaya = 0[13]	Busia = 13,600 Siaya = 16,800	Busia = 23,552 Siaya = 22,802
3.3	Percentage of collaborative health facilities that submit monthly FP commodities reconciliation reports to their headquarters by 5th day of the new month	Busia = TBD Siaya = TBD	Busia = 75% Siaya = 75%	Busia = 87.6% Siaya = 81.8%
Comment	3.1. Busia: Number reached through community-based distribution is 65,488, through outreach is 5,804 and through referral to facilities is 1,278. Siaya: Number reached through community-based distribution is 52249, through outreach is 12,841 and through referral to facilities is 9,143 3.2. Busia: Number reached through community-based distribution is 18,621, through outreach activities is 4252 and through referral to facilities is 679. Siaya: Number reached through community-based distribution is 12,137, through outreach activities is 4,143 and through referral to facilities is 6,522. 3.3. In Siaya and Busia counties the project, in collaboration with other partners, recruited and trained service providers on commodity management to streamline consumption and supply requests. This has seen timely submission/reporting of commodities reconciliation reports to their headquarters by 5th day of the month.			

[12]Program will serve three times more FP clients than the number of new acceptors

[13]There was no clear separation of each area's targets in Phase 1.

Outcome 4: Improved demand for FP services through effective outreach activities and distribution of IEC materials

Indicator	Description	Baseline 2012	Projected result 2015	Progress as at August 2015
4.1	The number of household visits made by CHVs per month to provide FP/RH messages (In Busia 3, 000 per month; In Siaya 4,000 per month)	Busia = 0 Siaya = 0	Busia = 60,000 Siaya = 80,000	Busia = 93,971 Siaya = 121,667
4.2	Number of demand-creation outreach events held per month by type (through theater groups, integrated health campaigns, or health days) (4 per month per site)§	Busia = 0 Siaya = 0	Busia = 80 Siaya = 80	Busia = 5,396 Siaya = 2,689
4.3	Number of people reached per month with FP/RH messages through outreach demand-creation activities (250 persons per session/event)	Busia = 0 Siaya = 0	Busia = 24,000 Siaya = 24,000	Busia = 281,641 Siaya = 120,426
Comment	4.1. Busia: 93,971 households were visited, reaching 103,111 persons with FP messages. Siaya: 121,667 households were visited, reaching 110,647 persons with FP information. Some households visited didn't have any persons of reproductive age or, if any, they were not available at the time of visit or declined to listen. In such cases, the total number of households visited would be more than persons reached with FP messages at household level. For instance the number of HH visited in Siaya County were more than the number of people reached with information at HH. 4.2 and 4.3. Busia: 5,396 demand-creation outreach events were held, reaching 281,641 persons with FP messages. Siaya: 2,689 demand-creation outreach events were held, reaching 120,426 persons with FP information. 4.3. In a double counting, there were no restrictions as to number of times a client would be reached with information. One client would be revisited with information.			

1: Program will serve 3 times more FP clients than the number of new acceptors

2: There was no clear separation of each area's targets in phase 1.

§ The project team anticipated that CHVs would hold joint meetings, hence a target of 80 per county. However, during implementation, every CHV was able to target women group meetings and barazas at different times of the month, which boosted the project's presence in these meetings.

Outcome 5: Improved social and policy environment for FP services through program monitoring activities and dissemination

Indicator	Description	Baseline 2012	Projected result 2015	Progress as at August 2015
5.1	Number of county stakeholders' forum meetings held to develop action plans for promoting positive image of FP (Busia; Siaya: 2 per year)	Busia = 0 Siaya = 0	Busia = 8 Siaya = 8	Busia = 8 Siaya = 10
5.2	Percentage of county health budget allocated to FP	Busia = 0 Siaya = 0	Busia = 5% Siaya = 5%	Busia = 36% allocated to RH Siaya = (Ksh 2 million allocated to RH, including FP.)
5.3	Functional management information systems installed during the first six months of the intervention	1	1	1
5.4	Number of reports and articles written using baseline survey M&E data	2	3	3
5.5	Number of dissemination meetings held	2	3	12
Comment	5.1. Busia: 2 county advocacy meetings were convened and 7 other stakeholders' meetings attended. Siaya: One county advocacy meeting was convened and 9 other stakeholders' meetings attended by all partners. The meetings included meetings funded by the project and other RH partners in the region and were attended by all PWK partners. 5.2. A meeting was held with the county administrations in February 2015 to lobby for resource allocation to FP. The officials from the two counties acknowledged their support for FP programs and have assigned budgets to support Community Health Volunteers' stipends and purchase of FP commodities. The County Government of Busia allocated 36% of its health budget to reproductive health. Siaya assigned 31% of its total budget to health, of which Ksh 2 million was allocated to FP. 5.3. The MIS system was redesigned in 2013, stationed at GLUK and used to capture project data. 5.4. In 2013, three papers using the baseline data were written, submitted for peer review and published. The writing of three other articles based on the MIS data is ongoing. The baseline survey report was printed and distributed in June 2014. One policy brief was also written. 5.5. 12 dissemination meetings have been held, two in 2012, two in 2013, three in 2014 and five in 2015. There have been four GLUK/ICFP conference and eight county advocacy meetings. Reports are available. These are only meetings that were supported by the project.			

APHRC CAMPUS, KITISURU, NAIROBI, KENYA
INFO@APHRC.ORG
@APHRC
AFRICAN POPULATION AND HEALTH RESEARCH CENTER