1995

Current experiences with community-based distribution of family planning in Kenya: A review prepared for USAID/Kenya

Population Council

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Introduction

Kenya has been one of the leading countries, not only in Africa but worldwide, in developing and implementing Community Based Distribution (CBD) programs as part of the national family planning program. CBD activities in Kenya are coordinated by the National Council for Population and Development (NCPD), with financial and technical support being provided by a number of donor agencies, most notably USAID. USAID has supported a wide range of CBD programs implemented by NGOs, many of which are now well-established having operated for more than ten years.

This review was requested by USAID/Kenya. The next USAID bilateral health and population assistance project is scheduled to begin in September 1995 and prior to that the Mission needs to develop its strategies for the project components. One of these components is anticipated to be continued support for CBD activities, which have in the past formed a major part of the Mission's population and health assistance to Kenya. The CBD program in Kenya has been widely publicized because of its apparent success in improving access to family planning information and services, and because of its wide diversity of organizational structures. USAID has been the major supporter, financially and technically, to this program and would like to review the current situation and possible future directions before designing its CBD strategy for the next five year bilateral project. The Africa OR/TA II Project was requested to assist the Mission in preparing its CBD strategy because of its experience with CBD activities throughout Africa, and because of the need to review analytically the available information.

Following this review, the Africa OR/TA II Project will be supporting and coordinating a large-scale field research study to evaluate the impact of CBD in terms of a variety of indicators. This review has provided the first step in preparing for this research study by identifying what is already known about CBD in Kenya and highlighting the key issues which need to be addressed.

This report presents, therefore, a wide-ranging review of data currently available on a number of aspects of CBD in Kenya. The data were collected from several sources, including existing summary reviews of CBD in Kenya[1]; data from questionnaires administered to CBD organizations during the two national conferences held at Silver Springs Hotel in August 1990[2] and April 1994[3]; and, most importantly, information gained directly from numerous organizations implementing CBD programs. Special thanks are due to all the staff contacted at these organizations for their time and energy spent in providing documents and service statistics, and in helping to clarify what is not always

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1 Lewis, G., N. Keyonzo & P. Mott (1992) "Community-based family planning services: Insights from the Kenyan experience" Paper presented at the Annual Meeting of the Population Association of America, Denver, Colorado.
Phillips, D., G. Lewis & D. Kabira (1993) Community Based Distribution Program in Kenya, Report to USAID/Kenya, The Population Council, Nairobi, Kenya.

2 Division of Family Health, National Council for Population and Development and The Population Council (1991) CBD Policy Guidelines Workshop, Silver Springs Hotel, Nairobi, Kenya.

3 Magiri, G. and N. Keyonzo (1994) "CBD Conference Questionnaire", Pathfinder International, Nairobi, Kenya.

obvious in written documents. A further source of data was the recent Kenya Demographic and Health Survey (KDHS) and staff at NCPD were extremely generous in undertaking many reanalyses of the original data set to provide the information presented in this report. Information was also collected from organizations implementing CBD programs that are not funded by USAID, notably the Ministry of Health and Nairobi City Commission, because it was felt that they could provide important and relevant data.

The paper firstly presents a brief overview and classification of the major CBD programs operating currently in Kenya. The evidence available by which CBD programs could be evaluated is then reviewed and discussed, including not only the conventional output indicators but also the coverage and relative contribution of CBD as a source of family planning information and services. Given the emphasis now being placed on family planning being one service within a broader range of reproductive health care services, the actual and potential role for CBD programs within such a program structure is considered. Finally, a number of the more pressing programmatic issues are reviewed briefly and some broad recommendations made for the possible future directions of USAID support.

Overview and Classification of CBD approaches in Kenya

CBD programs have a relatively long history in Kenya, the first program being established by the Family Planning Association of Kenya (FPAK) in 1982, followed by the Maendeleo Ya Wanawake Organization (MYWO) and Chogoria Hospital in 1983. Over this time period a number of different organizations, including both NGOs and the Ministry of Health, have developed CBD programs. A laissez-faire attitude by the Government towards the establishment of CBD programs has meant that no programmatic guidelines have been given to organizations interested in developing CBD programs; instead, each organization develops it own program and the NCPD fulfills a coordinating role. A national CBD workshop was held in 1990[4] at which some guidelines were drawn up relating to medical issues and screening checklist, logistics and health information systems, job remuneration and support for CBD agents, coverage, and selection, training, and supervision of CBD agents. These have remained guidelines only, however, and have not formally become Government policy, thus leaving room for flexibility in the way each organization interprets them. A questionnaire administered during the recent follow-up CBD workshop sought to ascertain the extent to which CBD organizations have followed these guidelines; the results are presented in the forthcoming workshop report[5]. In addition to trying to identify national policy guidelines, a National CBD Training Curriculum has been developed and this appears to be used by all CBD organizations, thus establishing some common ground in the way in the training of CBDs. An effort to develop a common, unitary MIS system has begun but to date such a system has not materialized.

As a consequence, every organization has developed its own model for CBD, guided by its understanding of the needs of the communities served and the organization's ability to support CBD agents in the field. This organizational diversity has already been reviewed and well-documented by Lewis *et al* (1992)[6] and Phillips *et al* (1993)[7], and the details need not be repeated here. Specific descriptions of every CBD activity in the country will be available soon through a CBD Inventory which is currently being developed by NCPD with support from UNFPA; this document seeks to update and broaden a CBD Inventory produced earlier[8].

Among the more than 20 different CBD programs (and organizational models) currently operating in Kenya, some grouping into broad types is possible. One way of classifying the CBD models has been provided by Phillips *et al*, in which

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4 Division of Family Health, NCPD and The Population Council (1991) *op cit.*

5 Magiri, G. and N. Keyonzo (1994) *op cit.*

6 Lewis, G., N. Keyonzo & P. Mott (1992) *op cit.*

7 Phillips, D., G. Lewis & D. Kabira (1993) *op cit.*

8 Kanani, S. & J. Barasa (1992) "An inventory study of community-based distribution of family planning", unpublished consultancy report to NCPD and UNFPA.

CBD programs are categorized according to the organizational philosophy of the implementing agency. Four distinct models are suggested by these authors: the MYWO model, the FPAK model, a generalized church-based model, and an urban-based program model[9]. We feel that a simpler approach is to classify programs according to the way in which the CBD agent functions; under this scheme the main approaches would appear to be:

1) Urban Clinic Outreach - full-time salaried CBD agents working in the communities surrounding an urban clinic, but based at and fully supported by the clinic.

2) Rural Village Depot - part-time CBD agents based in their own rural community, supervised either by staff from the nearest clinic or by staff from the implementing organization itself. CBD agents may either visit clients at their homes or clients may come to them.

3) Employer-Based - part-time CBD agents serving the employees of, and supported by, a commercial company. May either be employees of a company health clinic or volunteer company workers. This approach could be seen as a type of village depot approach, the "village" being the company workforce.

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[9] "In the *Kiharambee* (i.e. MYWO) model, organizing strategies and resources are derived from the people, through established community institutions, reflecting diverse community needs, village institutions, and collective preferences. The *Kimamlaka* (i.e. FPAK) model purveys services that are assumed to be good for the people served, under the organization assumption that services are too complex or technical for villagers to manage themselves. The *Kiparishi* (i.e. church-based) model is an approach that emerges from church organizations, with elements of both the Kiharambee and Kimamlaka models, and strong reliance on volunteerism through church service. The *Kimandaraka* (i.e. urban) model, which comprises some elements from Kimamlaka and Kiparishi models assumes that the people in urban areas are more educated and have higher demand to control their fertility, thus motivation is already there to use family planning services" (Phillips *et al*, *op cit*, page 21).

Table 1 A Typology of Approaches to CBD in Kenya

Agency	# CBDs	CBD model	Organ-ization	CBD status	Clinic supervision
MOH/DFH/GTZ	4038	RVD	MOH	volunteer/incentive	_
MYWO	1236	RVD	NGO	volunteer/allowance	
MOH/Ken-Finland	1170	RVD	MOH	volunteer/incentive	_
FPAK	764	RVD	NGO	volunteer/allowance	(_)
AMREF	565	RVD	NGO	volunteer	
Chogoria	420	RVD	Church	volunteer	_
Maseno West	400	RVD	Church	volunteer/allowance	_
CHAK	366	RVD	Church	volunteer	_
FPPS	210	EB	Commer	volunteer/salary	_
SDA	100	UCO	Church	salary	_
FLPS	80	UCO	NGO	volunteer/allowance	_
NCC/FP project	44	UCO	MOH	salary	_
CMA	35	UCO	Church	salary	_
Kabiro	30	UCO	NGO	salary	_
Mkomani	29	UCO	NGO	salary	_

As Table 1 shows, the choice of Urban Clinic Outreach (UCO) or Rural Village Depot (RVD) approach does not appear to be determined by the type of organization implementing the program; there are examples of both approaches being implemented by the Government, by NGOs and by church-based organizations. The employer-based approach (EB) supported by the Family Planning Private Sector (FPPS) Project, is implemented by individual commercial companies.

Only three programs, MYWO, FPAK, and AMREF, appear to be freestanding, that is, have no direct links with a health clinic; the FPAK CBD agents do refer clients to an FPAK clinic if one is located locally. The programs using the freestanding approach have instead developed strong field-based supervisory structures through which their CBD agents are supported, but their agents do rely on the willingness of the local health clinic to accept their referred clients. For the other RVD programs, the CBD agents are linked with a clinic directly, both for supervision

and logistical support. The MOH programs (DFH/GTZ and Kenya-Finland[10]) are linked directly with MOH clinics, and the church-based programs (CHAK, Chogoria and Maseno West) are linked with each organizations' own clinics.

The UCO programs are, by definition, linked directly with a clinic for all their support and supervisory activities. These clinics are either run by the NGO itself, or in the case of the Nairobi City Commission (NCC) by the Ministry of Health. In the employer-based program supported by the FPPS Project, the CBD agents are linked with the company health clinic, either directly as members of the clinic staff (e.g. as nurse aides) or as company employees acting similarly to the RVD CBD agents.

One of the strongest recommendations made during the first national CBD workshop was that "CBD agents should not be full-time salaried workers. They should be either part-time paid workers or unpaid volunteers". As shown on Table 1, however, five CBD programs employ full-time salaried workers (earning 1500 - 2800 KShs per month), all of which operate through the UCO approach. Four programs (MYWO, FPAK, Maseno West and FLPS) could be described as having part-time paid workers, in that although the CBD agents are seen by the organization as part-time volunteers, they are given a monetary allowance of 250 - 400 KShs per month, ostensibly as a travel allowance. One organization, the SDA, has developed a commission scheme by which CBD agents are paid according to the number of clients they serve[11]. The two MOH RVD programs, supported by GTZ and FINNIDA, provide non-monetary "incentives" for their volunteer CBD agents, such incentives including bags, stationary, and certificates; these items are provided to many of the salaried and part-time CBD agents in other programs also.

Only three programs (AMREF, CHAK and Chogoria) have what could be described as genuinely voluntary agents in that no allowances or incentives are given. In responding to the second national CBD workshop questionnaire, however, two of the programs expressed concerns about their ability to maintain completely voluntary programs[12]. The FPPS program is a little different in that some CBDs are volunteers from amongst the company workforce, whereas others are actually staff from the

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[10] The "Kenya-Finland" Program is actually more of a general PHC program, but its community agents provide family planning services and operate very similarly to the CBD agents of the MOH/GTZ family planning CBD program.

[11] A study of this innovative approach would be useful to identify whether it is effective and avoids the many problems which have been encountered in other programs when providers are paid an incentive to recruit new acceptors.

[12] One organization commented that incentives are "becoming necessary. The rate of dropouts where it is not given is very high. In the end the programme becomes very expensive". The second organization also stated that incentives are "very necessary" and in their policy guideline recommendations stated "let us discuss this and find ways of creating incentives for them". (The third organization did not complete the Silver Springs II questionnaire).

company health clinics, such as nurse aides, who are employed by the company but not specifically to be CBD agents, i.e. they would be paid the same amount whether they were family planning CBD agents or not.

This raises an important issue of definition - can full-time, salaried clinic outreach workers be labelled as CBD agents? Moreover, is it appropriate to compare programs in which the status of the CBD agents differs on such a fundamental issue of employment status? Perhaps it would be more appropriate to recognize that there are two types of community-level agents providing family planning and other reproductive health services: those employed as clinic outreach workers and those working as village depot workers. Such a distinction should differentiate the way in which support for CBD programs is planned, certainly in terms of their financing and cost-recovery, the range of services provided, and the supervision and support provided to the CBD agents. These issues are considered in more detail in later sections.

Evaluating CBD Activities

Coverage

Table 1 shows that there is a wide range in the sizes of the CBD programs, but this is not reflected in terms of their geographic coverage. For example, the two MOH programs total more than 6,000 CBDs but cover only seven districts, whereas the MYWO program has 1,236 CBDs in 10 districts and the FPAK program has 764 CBDs in 18 districts. The other programs with national coverage are the church-based SDA and CHAK programs, which have 100 CBDs in 12 districts and 463 CBDs in seven districts respectively. The FLPS, NCC, CMA, Kabiro and Mkomani programs are all located in urban areas and therefore have smaller catchment areas but presumably a higher density of clients.

Another dimension to the issue of coverage is the population served by CBD programs. This can be measured in two ways: the number of persons or households served by each CBD agent; and the proportion of the population covered by CBD programs. The number of persons or households served by individual CBDs has proved an elusive measure as this statistic is not routinely recorded by CBD organizations. The first national CBD workshop produced guidelines for the ratios of women of reproductive age per CBD agent and FP clients per CBD agent. Responses to the second national CBD workshop questionnaire revealed, however, that only eight of the 14 organizations had actually produced their own guidelines on CBD agent coverage, suggesting that the issue is difficult to implement.

Catchment area surveys, for example, of the MYWO[13] and Mkomani[14] programs have the potential to provide empirical evidence of the actual number of women of reproductive age and FP clients served by their CBD agents. Reanalysis of the MYWO survey data, for example, gives averages of 1,324 people and 315 women of reproductive age covered per CBD agent. The MYWO survey also reveals that in the sublocations where the CBD agents operate, approximately 66% of the population are covered. This suggests that any assessment of the geographical coverage by CBD programs should not assume that the assignment of a particular sublocation to a CBD agent(s) means that the entire population within the sublocation is covered.

The proportion of the national population covered by CBD programs has also not been rigorously assessed. The 1993 KDHS revealed that 48% of women live in communities served by CBD agents, although this varies greatly by province. Only 21% of

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[13] Kekovole, J. (1993) Maendeleo Ya Wanawake MCH/FP Project Catchment Area Survey, MYWO, Nairobi, Kenya.

[14] Mburugu. E. (1994) Mkomani Clinic Society Family Planning and Community Based Services Project Catchment Area Survey, Pathfinder International and Mkomani Clinic Society, Nairobi, Kenya.

women interviewed, however, actually knew of a CBD agent in their area, suggesting that many CBD agents are not accessible because they are not known within their own communities. The highest proportions of women knowing a CBD agent were found in Western (33%), and surprisingly, Coastal (29%) Provinces.

It is hoped that a complete mapping of the geographic coverage of CBD programs nationally will be possible when the NCPD/UNFPA CBD Inventory is completed. Data collected through this review can, however, give an initial picture of the current distribution of CBD programs. The Appendix describes the distribution nationally by district for the largest, rural-based CBD programs according to the data currently available. The ratios of population per CBD agent are obviously gross estimates (calculated by dividing the number of CBD agents by the total population for the district as given in the 1989 national census), but they serve to illustrate the wide ranging density of coverage by CBD programs around the country. This data could be useful when deciding future areas in which new CBD programs could be initiated. The most densely covered provinces (i.e. those with the lowest population per CBD ratio) are Western and Nyanza, a result supported by the KDHS which recorded 65% and 67% respectively of women living in areas served by CBD agents.

Program effectiveness

Measuring and comparing the outputs and effect of CBD programs requires that valid and reliable data are available. In collecting data for this review it became apparent that virtually all organizations are not able to provide reliable service statistics. For example, the statistics reported to the USAID CBD Manager for 1993 by the USAID-supported CBD programs did not match the statistics given by the same organizations in their responses to the second national CBD workshop questionnaire. Although there were no major differences, the fact that discrepancies did exist suggest that there is a need to focus attention on the recording and reporting of service statistics in the future. Bearing in mind this limitation, the following indicators should be interpreted as giving overall guidance only in assessing the performance of the CBD programs reviewed, and should not be seen as definitive measures of actual program performance.

In comparing the outputs of the CBD programs, the indicators used are the average rates per CBD agent rather than total outputs per program so as to control for the different sizes of each program. Two output indicators are used, the average number of clients seen per CBD, and the average number of CYP provided per CBD.

Figure 0 Average Number of Clients Seen per CBD Agent in 1993

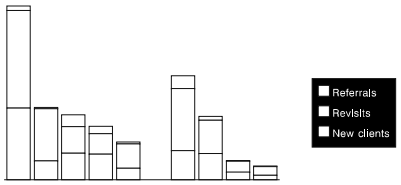


Figure 1 overleaf describes the average number of clients seen per CBD agent for nine programs in 1993. The number of clients seen is calculated by totalling the number of new clients, revisit clients, and clients "effectively" referred by a CBD agent. The FPAK program, and to a lesser extent the MYWO program, have performed well on this indicator given that their CBD agents operate part-time and mostly in rural, low-density areas. Moreover, for this indicator they have out-performed some of the full-time urban clinic outreach CBD agents, such as the Kabiro and NCC programs[15]. The range of services provided by a CBD program will probably influence the performance of its agents, however; many of the UCO CBD agents also provide other PHC services and thus do not focus exclusively on family planning services, as is the case with the RVD programs.

For all programs except those run by FLPS and Kabiro, CBD agents are seeing more revisit than new clients. This suggests that they tend to spend at least as much time resupplying current users as counselling and providing services to new clients. It is important to consider whether this is a preferable role for CBD agents, or whether some of the resupply function could be fulfilled by other means, such as the contraceptive social marketing program. For all programs, with the possible exception of the SDA program (see footnote 14), relatively few clients are being referred for clinical methods. This could be due to a number of reasons such as: both clients and CBD agents see the CBDs' role as dealing with those non-clinical methods which they can provide; CBD agents are not sufficiently comfortable with clinical methods and the referral process to discuss them with clients; or there is poor reporting and recording of effective referrals. Further research could help to identify why there is apparently so little referral, and to seek ways to strengthen this function.

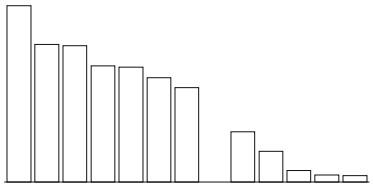
An interesting comparison can be made between the average number of new and revisit clients using condoms, pills and foam tablets served by CBD agents, and the equivalent average number served by MCH/FP clinics. The average number of new and revisit clients seen by CBD agents for the four largest programs in 1993 were: Mkomani (912); FPAK (490); CMA (382);

[15] The SDA program, the remaining example of a Clinic Outreach model, was not able to provide data for the number of new and revisit clients. The program did report an average of 863 referrals per CBD, more than ten times the next best program (FPAK), but there is some confusion over the way in which this figure was calculated.

and MYWO (320). The 1989 Kenya Situation Analysis study revealed an average of 900 new and revisit clients for pills, condoms and foam tablets per clinic[16]. Bearing in mind that this is an average figure, and that more than half of the 99 clinics visited actually served less than 500 of these clients annually, there would appear to be strong evidence that many individual CBD agents are operating as effectively as an entire clinic. This is obviously a simplistic interpretation, but it places the effectiveness of CBD programs in a more comparative perspective.

The indicator of `number of clients seen' describes the overall level of family planning activity undertaken by CBD agents. Protection against pregnancy amongst clients is measured through the Couple-Years of Protection (CYP) indicator. Figure 2 describes the average CYP provided per CBD agent in 1993. The most interesting issue is that the distribution of the program scores does not match that shown on Figure 1; there is a clearer distinction between the UCO and Employer-Based agents, and the RVD agents. The probable reason for the difference is that the CYP indicator is based on the number of contraceptives distributed. One new or revisit client is recorded whether they are supplied with a single condom or 13 cycles of pills, and consequently the CYP indicator is dependent on both the method mix and the quantity provided to each new and revisit client.. This raises the issue of which is the more appropriate indicator to use. It is difficult to address this question without a broader consideration of what the role of the CBD program should be, as any evaluation indicator should address a program's goals. It is probably preferable to use both indicators jointly in any program assessment as they each provide complementary measures of how a program is functioning[17].

Figure 0 Average CYP Provided per CBD Agent in 1993



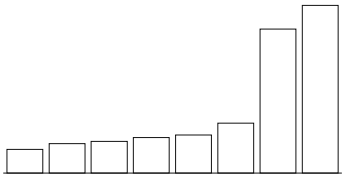
[16] This figure was calculated from data presented on page 26 of the study report (Division of Family Health/Ministry of Health and The Population Council A Situation Analysis of the Family Planning Program of Kenya: The Availability, Functioning and Quality of MOH Services, The Population Council, Nairobi, 1989).

[17] USAID is no longer required to report CYP and prefers instead to report the number of users or referrals for each method.

Program efficiency

Managers and donors in Kenya are mostly convinced that the CBD approach can be effective; the question remains, however, as to which approach is the most efficient. Efficiency is a measure of the relationship between the inputs to and outcomes of a program, and is frequently assessed in terms of the relative cost-effectiveness, or cost per unit output of different programs. Cost data are notoriously difficult to collect and interpret; Figure 3 (overleaf) presents the best data available at present[18] to measure program efficiency, namely, the average total cost per CYP for a number of USAID-supported CBD programs. These data were obtained by simply dividing the number of CYP for the program by the total amount reported to have been spent on CBD activities. This amount includes, therefore, all costs associated with service delivery, IEC activities, administration, personnel, supplies, travel, etc, and so the figures are extremely crude. Any future analyses of CBD costs must break these figures down so as to get a better understanding of the allocation of costs within the different components of the program.

Figure 0 Average Cost per CYP for USAID-supported CBD programs in 1992



With the possible exception of Maseno West[19], there appears to be little real variation between the programs for this indicator. In relative terms the MYWO program is only half as efficient as the CMA program, but both would appear to be within acceptable levels of cost per CYP for CBD programs[20]. Moreover, for the two programs for which data over a three year time period were available (FPAK and Chogoria), there is only a $2 per CYP variation between the highest and lowest amounts, suggesting that a stable level of efficiency has been reached, at least for these two organizations.

There are at least two problems, however, in relying on this indicator for a meaningful representation and comparison of

[18] With support from Pathfinder International, MYWO has recently undertaken a detailed cost analysis of their CBD program and the results from this study should be available before the end of 1994.

[19] The cost/CYP for CHAK reduced in 1993 to $11.37, suggesting that the program has been able to improve its efficiency to about the same level as the other programs. It is not known whether Maseno West has also been able improve its efficiency.

[20] For example, data from cost analyses of seven CBD programs give a range of cost per CYP for pills from between $5.30 in Colombia to $29.30 in Morocco, and for condoms of $21.70 in Honduras and $50.53 in the Dominican Republic (B. Janowitz & J. Bratt (1992), "Costs of family planning services: A critique of the literature", International Family Planning Perspectives, 18,4:137-144). Recent evidence from Zimbabwe indicates a cost per CYP of approximately $3.73 for the rural-based, full-time CBD agent program (Roxanne Rogers, USAID/Zimbabwe, personal communication).

program efficiency. First, the use of cost per CYP places an emphasis on the use of an outcome indicator which is itself rather problematic[21], as reflected by USAID/Kenya's discontinuation of reporting CYP figures. This could be addressed by replacing CYP with the number of clients seen or some other summary output indicator. Secondly, the use of aggregate cost data for an entire program is extremely misleading as it gives no indication of the relative expenditure on, for example, the CBDs themselves and commodities provided, on support and logistics, or on central administration. There is clearly a need for a more rigorous cost analysis of selected programs before firm conclusions can be drawn about the relative efficiency of different CBD programs.

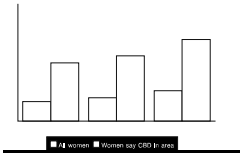
[21] For a review of the strengths and weaknesses of CYP see J. Shelton (1991) "What's wrong with CYP?" Studies in Family Planning, 22,5:332-35.

Contribution of CBD Programs as Sources of Family Planning Information and Methods

One of the key issues arising when evaluating the role of CBD programs within the national family planning program is the extent of their overall contribution as sources of family planning information and methods. Two types of data are used to address this issue, the KDHS and a Catchment Area survey carried out for MYWO.

The KDHS included questions on how women first heard about family planning, from which place or person they learned the most about family planning, and, for current users, their last source of method supply. Figure 4 presents the results for two groups of respondents, all women interviewed and those women who said that they knew there was a CBD in their community. The first group give an indication of the contribution of CBD agents nationally, and the second group reflects the fact that CBD programs do not cover the whole country; this group represents the 21% of the national sample who knew that a CBD agent operated in their community and thus actually have access to a CBD agent[22]. The national figures have caused some concern because they suggest that the CBD programs are contributing very little nationally as a source of information and/or methods. The sub-sample of respondents who know of a CBD show a higher level of utilization of CBD services, but the amount of attention paid to CBD programs in Kenya had raised hopes that it had become a major source of family planning information and services nationally. There remains a need, however, for re-analysis of the KDHS data to find out more about the types of clients that are using CBD agents. The questions used and the presentation of data in future DHS studies also need attention.

Figure 0 CBDs Contribution to FP Information and Method Source by Client's Awareness of CBD in Community



Given that CBD programs do not operate throughout the country, and that even where they do operate they do not fully cover the district, or even the division or sublocation, the MYWO and Mkomani Catchment Area surveys provide a unique opportunity to describe the contribution of CBD agents in areas where they do operate as a fully integral part of the overall family planning program. The MYWO Catchment Area study has been implemented in

[22] The DHS Service Availability Questionnaire recorded that in fact 48% of respondents lived in areas served by CBDs, although not knowing the availability of a CBD agent means, in effect, that the agent is not a potential source of information or methods. Appendix 1 shows that CBD programs operate in at least 26 districts (plus Nairobi and Mombasa), i.e. 65% of the country, but there coverage within a district is never total (see discussion of the MYWO Catchment Area Survey).

several phases; results are currently available from the first phase only.

Figure 0 Contribution of CBD agents as sources of information and methods for current users in five MYWO program divisions in 1993

The entire population of five divisions in three districts (Kakamega, Kirinyaga, Machakos) were interviewed, and it was found that on average 66% of the population in these divisions were served by CBD agents, that is, were living in areas covered by a MYWO CBD agent. Figure 5 illustrates that at the division level, the contribution of a CBD program is, as would be expected, much greater than nationally, with CBD agents (MYWO and others) providing information and methods to 35% and 28% of current users respectively. Clinics remain, however, the major source of information and services. At this level of measurement it would also be helpful to find out the relationship between the CBD agents and the clinics, in terms of referral for clinical methods, resupply and problems. Whether similar levels of contribution are found in areas served by other CBD programs can only really be addressed by undertaking further catchment area surveys.

Actual and Potential Role of CBD Agents as Reproductive Health Care Providers

USAID's Office of Population has recently established as one of its priority policies the addition of selected reproductive health interventions to its current portfolio of population program support. Thus when considering the role of CBD programs supported by USAID it is important to broaden the discussion to include elements of reproductive health care other than family planning services. These elements include HIV/STD prevention, post-abortion contraception, breastfeeding and safe motherhood[23]. To date, most CBD programs have begun to address HIV/STD prevention.

Table 2 STD/HIV/AIDS activities undertaken by CBD Programs

Agency	Education	Counselling	Condom Distribution	Referral to Static Facility	Training
CHAK	%	-	%	%	%
Maseno West	%	-	%	%	%
FLPS	%	%	%	**	-
FPAK	%	-	%	-	-
Mkomani	%	-	%	%	-
MYWO	%	-	%	-	%
NCC	%	%	%	%	%
SDA	**	**	%	**	-
Kabiro	%	-	%	-	-
CMA	%	%	%	%	-
DFH/GTZ	%	%	%	%	%

** From personal conversations it is believed that these services are available.

In February 1994 Pathfinder International coordinated a national HIV/AIDS/STD/FP Integration Symposium to review systematically current and planned integration activities in Kenya. A

[23] Maguire, E. (1994) "USAID's Office of Population: Program Priorities and Challenges", Partnerships, Opportunities and Challenges: A Vision for the Future, Summary of Proceedings of the 1994 Cooperating Agencies' Meeting, POPTECH, Arlington, USA.

questionnaire administered to participants prior to the meeting provides up to date information on current STD/HIV activities within CBD programs, which are summarized in Table 2. It reveals that most FP CBD programs are already involved in STD/HIV activities. Nearly all of the programs included are providing education and distributing condoms, while a smaller number are also counselling and/or referring clients. All of these activities, apart from referral, are basic level prevention activities.

It could be argued that any family planning program would not be offering high quality services without paying attention to STDs. For instance, providers should inform clients of the STD protection that various methods of contraception do or do not provide, and people at risk of STDs, including HIV, should be advised to use condoms, with or without another method. It is also important, however, to consider the extent to which CBD agents should be offering services beyond providing family planning information and contraceptive methods. It is possible that the integration of any other type of service into the CBD agents' role could be detrimental as these may detract from the family planning activities. This may be especially true where a CBD worker is a part-time volunteer with limited time and energy to dedicate to her/his community role. There may also be, however, a missed opportunity in not expanding the role of CBD agents as the enlargement of the CBDs' role could add prestige and status, thereby contributing to the successful fulfillment of family planning work. Evidence from other studies does suggest that family planning staff can be trained to deliver STD services without detracting from their primary mission and that there is the potential for mutual benefits through the reduction of both unwanted pregnancy and STDs through a more comprehensive approach[24].

If the role of the CBD is to be further extended within the broader context of reproductive health, it is important to identify how existing family planning services could be expanded. Generally, STD/HIV services can be divided into two categories: prevention and management. During the Integration Symposium, USAID Cooperating Agencies in Kenya expanded on these two categories (see below) to assist in developing program activities which meet client needs and maintain a workable program. It was stressed that CBD programs must take account of their `absorptive capacity' and undertake only those activities which their infrastructure allows[25].

[24] Elias, C., A. Leonard and J. Thompson (1993) "A Puzzle of Will: Responding to Reproductive Tract Infections in the Context of Family Planning Programs" Paper presented at the Population Council's Africa Operations Research and Technical Assistance Project Conference, Nairobi, Kenya.

[25] HIV/AIDS/STD - Family Planning Integration Symposium: Final Report 1994, coordinated by Pathfinder International, Nairobi, Kenya.

BASIC LEVEL OF ACTIVITIES - PREVENTION (Clinical; CBD/Outreach)

- Information and Education
- Counselling
- Risk Assessment Interviewing
- Condom Distribution

SECOND LEVEL OF ACTIVITIES - MANAGEMENT (Clinical only)

- Diagnosis
- Referral
- Treatment

The USAID Cooperating Agencies agreed that only the basic level of activities could be undertaken by CBD agents, but this raises a number of questions which need to be addressed when planning the expansion of CBD roles:

- What type and level of STD services should be integrated into FP services at the community level, and what are the associated training needs?

- How much can be expected from CBD agents? What can they do in terms of providing other non-family planning services? Does this differ in terms of the type of CBD program / agent?

- How should CBD agents be selected in order to best carry out activities beyond family planning and reach identified target groups (adolescents, men etc)?

- What is the effect on resources, especially cost?

These questions need to be addressed before firm recommendations can be made. Approaches to addressing these questions could include preparing in-depth case studies of the current experiences of those CBD programs which provide STD/AIDS-related services, and undertaking pilot testing of innovative models of FP/STD/HIV integration for CBD programs[26]. In undertaking such studies it is essential to

[26] Through funding from the USAID-supported HAPA Project and coordination by REDSO/ESA, the Africa OR/TA II Project, Pathfinder International and Harvard University are about to begin a study that will review current experiences and pilot test new approaches to FP/STD integration in selected countries

distinguish between full-time Clinic Outreach and part-time Village Depot agents, as their employment status and support and supervisory systems will largely determine what they could be expected to do.

Priority Programmatic Concerns

The purpose of this review was not to address the many programmatic issues which always arise when developing and implementing CBD programs. The report of the second national CBD workshop[27] presents the results from a questionnaire administered to 15 CBD programs and describes most of the key programmatic issues and how they are being addressed by the programs. In undertaking this review it became apparent that, in addition to the remuneration of CBD agents and their role in a broader reproductive health program, two other issues dominate in considerations of future program design. These are the need for pill clients to have a medical examination, and cost-recovery through CBD programs charging for their services.

Medical examination for CBD pill clients

The issue of whether or not new pill clients should receive a medical examination prior to being issued with supplies by a CBD agent has been a topic of debate in Kenya. Related issues include how many cycles a CBD can distribute without an examination, examination requirements for continuing pill clients and the use of a checklist for contraindications by CBD agents. International experience has shown that risks to women taking low-dose oral pills are extremely low, especially with a good checklist. Furthermore, the benefits of pills being easily available without possible barriers such as the requirement for a physical examination are great, especially in areas of high maternal mortality.

Recommendations were developed during the first national CBD workshop which included the following:

1. Physical examination should be **encouraged** for all new and continuing FP clients near the beginning of oral pill use, and yearly thereafter.

2. CBD agents should review the checklist with the client on each contact.

3. CBD clients should be supplied initially with one cycle of pills. Clear directions for their use should be given along with referral for a physical examination.

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throughout the region, including Kenya. Under this project it may be possible to address this issue with specific reference to CBD programs.

[27] Magiri, G. and N. Keyonzo *op cit*

4. A physical examination ... should be carried out within four months with an upper time limit of seven months.

The questionnaire completed for the second national CBD workshop revealed that Kenya's CBD agencies continue to differ in their guidelines and practices regarding clinical medical examinations, check-ups and use of checklists by CBDs. Only the MOH/GTZ program has no medical examination requirements for new or continuing clients. Less than half of the programs require a medical examination for new clients, with the majority requiring either the CBD to use a checklist, or that some pills are issued and the new client is recommended to go for a medical examination when convenient. All programs, except the MOH/GTZ and Maseno West programs, require a medical examination for continuing clients.

A study has been undertaken in Kenya which compared the efficiency of the CBD checklist for identifying contraindications with the routine physical examination by enrolled nurses in clinics, in terms of correctly indicating and contraindicating pill clients[28]. The study showed that the CBD agents screening using the checklist was significantly more successful at correctly identifying contraindications than the enrolled nurses judgement from a physical exam. This may be because they usually know the client already through being a neighbor, and because their lower client loads mean that they can spend more time during the screening process. The results from this study were presented to a Kenyan medical symposium on physical exams for pill users in CBD programs, the conclusions of which were that low dose pills only should be provided, and if they are, then a physical examination should not be mandatory but should be encouraged whenever possible[29], i.e. the symposium supported the recommendations from the first national CBD workshop.

The issue of a mandatory medical examination reflects a wider concern with the quality of service provided by CBD agents - can they match that provided by clinical service providers? Further evidence that they can match, and possibly exceed, the quality of care provided by clinical staff is provided by a recent study which demonstrated that 12-month continuation rates for pill users in the MOH/GTZ CBD program were somewhat higher (74%) than comparable national figures (56%)[30]. Continued use of contraception is commonly seen as a key outcome of a quality service being provided.

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[28] Muindi, F. (1992) "Community Based Approach to Family Planning in Kenya" MPH thesis, Dept. of Community Health, University of Nairobi.

[29] Rogo, K. and P. Ndavi (1993) "CBD Programme: Oral Contraceptives and the place of Physical Examination", Kenya Obstetrical and Gynaecological Society.

[30] Ferguson, A. (1993) Pill Continuation amongst Clients of CBD Agents in a Rural Area of Kenya, GTZ Family Planning Project, Ministry of Health, Nairobi.

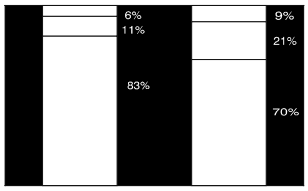
Paying for services

The policy of the Government of Kenya is that publicly-provided family planning services should be free to clients. Many CBD programs are now considering the possibility of introducing charges for services as a partial cost-recovery mechanism to reduce their dependence on donor support. Charging for family planning services in the private sector is not new, however: some of the church-based organizations (e.g. SDA, CMA) charge for family planning services in line with their policy to charge for health services generally, and the social marketing program charges for condoms[31].

Willingness of clients to pay for services which were previously free is often perceived as a major obstacle to introducing service charges. Evidence from social marketing programs around the world demonstrate that if the price is set carefully clients are willing to pay a small amount for condoms and pills. Further evidence can be gained from a study undertaken recently in Kenya by the MOH/GTZ Family Planning Project. In the study 1,000 clients of CBD agents from 10 programs in 16 districts were asked their feelings about paying for family planning services. Overall, 82% of respondents said that they would be willing to pay.

To explore the issue of price elasticity, clients were asked their willingness to pay for pills and condoms at different costs. Under the lowest cost scenarios, 91% of respondents said that they would be willing to pay 5 shillings for a cycle of pills and 92% would pay 50 cents for a condom; only 3% said that they would stop using if they had to pay this amount. The results for clients' willingness to pay the highest levels of cost are given in Figure 6. It is worth noting that the current price in the social marketing program is 10 shillings for three condoms. This study suggests that at these prices about three quarters of CBD clients would be willing to pay, particularly for condoms, and only 6 - 9% would consider stopping altogether. These results assume of course that willingness to pay can be translated into actually paying if the charges were introduced. Tentative evidence from Zimbabwe suggests that the introduction of charging for pills and condoms had an initially drastic effect on their use, although the level of

Figure 0 **CBD clients' willingness to pay for contraceptives**



[31] The social marketing program originally sold pills, but this was found to be unsuccessful. Whether this was due to the price charged the brand used (which was different than the usual MOH brand) is not clear.

use picked up slightly over time[32].

[32] Roxanne Rogers, personal communication.

Conclusions and Discussion

This review confirms that the many CBD programs in Kenya are now well-established and are fully accepted as an integral part of the overall national family planning program. Currently available data only were used and thus many of the findings are already known, but the purpose of the review was to consolidate this information so as to present an overall picture of the situation to guide future planning. The key conclusions are as follows.

1) There is a need to recognize that there are essentially two broad types of CBD program operating in Kenya, those that serve a largely rural population through part-time paid agents or unpaid volunteers, and those that operate in urban environments through full-time paid agents based in health care clinics. According to the definition of a CBD program agreed upon during the first national CBD workshop, only the first category would qualify as CBD agents. Evaluation indicators presented here suggest that the full-time clinic-based CBD programs are clearly more effective in terms of CYP provided, and are marginally more effective in the number of clients seen; there are insufficient data to make conclusions about their relative cost-effectiveness. Given that both serve different populations in different ways, there is no reason not to continue supporting both approaches. In developing future plans for their support, however, it is important that consideration be given to the different potentials for each approach. For example, the clinic-based full-time workers could be expected to be better able to expand their role into undertaking more effective referrals for clinical methods and into providing other reproductive health services.

2) To be able to make decisions regarding future allocation of funds between different programs, there is an urgent need to undertake an economic appraisal of the CBD programs. Cost data currently available are at an aggregate level only, and need to be analyzed in detail to make meaningful conclusions about a program's cost-effectiveness. A cost analysis for each of the major programs that receive donor funds which breaks down costs by their functions within the organization would go a long way to assisting in identifying how programs could become more efficient, and would provide a better base on which to compare different programs.

3) Many national health care systems throughout Africa are developing health care financing schemes which place an emphasis on cost-recovery through charging fees for services and commodities. Kenya is already charging for drugs and consequently there is the possibility that charging for contraceptive services could be introduced.

Charging for contraceptives already occurs in Kenya through the private sector and social marketing programs, with apparently little effect on the overall efficiency of service delivery. Very little is known about the price elasticity of family planning services, however. Data from a recent study in Kenya suggests that, hypothetically, prices are fairly inelastic, that is, an increase in price would not lead to a proportionate decrease in demand, but evidence from a country where prices were introduced (Zimbabwe) showed a very real drop in demand initially. It is essential, therefore, that any intention to introduce service charges be preceded by a demand study to ascertain price elasticity and thus the appropriate pricing level and best mechanism through which to administer the charges.

4) Linked directly to the issues of program efficiency and cost recovery is the payment of CBD agents. The philosophy that CBD agents should be volunteers is strong in Kenya, although this review shows that true volunteerism is actually rare and hard to sustain; even programs giving incentives to their volunteer CBDs have high levels of discontinuation and declining productivity over time. For those programs which believe that CBDs should not be full-time salaried workers, attention must be paid in the near future to working out ways in which their agents can best be motivated to work at an acceptable level of productivity and to continue at that level. Charging fees for services may offer one option as it would enable CBD agents to work on commission. Financial incentives linked to performance are, however, notoriously difficult to implement in a way that would not encourage possibly coercive methods by the CBD agent to try to maximize their income.

5) The issue of payment of CBD agents, and consequently the cost implications for their support, is linked to their function within the national family planning program, and to their role relative to other family planning sources, notably public sector clinics and retail outlets for the social marketing program. Although nationally CBD programs appear to make little contribution as a source of family planning information and services, in the areas where they do operate their role appears to be relatively important. It is essential, therefore that the future direction of CBD programs, in terms of mode of operation as well as geographic coverage, is planned jointly with the provision of services within clinics. The majority of the Kenyan population live within relatively easy access of clinical facilities, and so when planning CBD programs it is necessary to ensure that their functions are coordinated with the clinics. Whether they should operate as first contact points for clients who are then referred to clinics, or should be independent sources, or

some combination of these functions must be decided in conjunction with the clinics.

6) The high profile attained nationally and internationally by CBD programs in Kenya has masked the fact they do not cover the entire country and that only a small proportion of the population actually has easy access to a CBD worker. This finding suggests that the relative cost-effectiveness of CBD versus clinical service delivery should be measured, and the proportion of the national family planning budget allocated to CBD activities assessed in terms of their contribution to the overall supply of services. The data in the Appendix also suggest that the location of CBD programs needs to be more carefully planned as there is clearly a clustering of activities in certain districts, which is not necessarily linked to the population density in those districts. It could be argued, for example, that CBDs are a particularly appropriate service delivery mechanism in areas with poor clinical facilities and a low density population, and yet there are no CBD programs in the Northern Province which exemplifies these characteristics.

7) The review of CBD agents current and potential role as reproductive health care providers focussed on their activities in HIV and STD prevention. There seems to be already substantial experience in training and supporting CBD agents to educate, inform and counsel, particularly in HIV prevention and to a lesser extent in STD prevention. It would be useful, therefore, to more fully document and assess the effectiveness of these on-going activities so as to better inform future support. The area of risk assessment has also been identified as a possible activity which CBD agents should be better trained in; a pilot study to test risk assessment training would be useful in developing modules that could be incorporated into the national CBD training curriculum. There is little evidence available of CBD agents working in other areas of reproductive health, notably encouraging effective breastfeeding and monitoring maternal and infant morbidity, and these are areas which have the potential to be built into the CBD agents' role, certainly for the full-time agents.

8) In undertaking this review the uneven quality of data available and the difficulty in being able to address even basic evaluation issues suggests that there is a need to pay greater attention to the recording and

reporting of service statistics and cost data, and a need for a few discrete research studies to answer specific evaluation questions. Table 3 overleaf lists some of the evaluation questions which need to be addressed to strengthen the information base on which future planning for support to CBD programs in Kenya can be made.

Table 3 Evaluation questions for CBD programs in Kenya

QUESTION	INDICATOR(S)	DATA SOURCE(S)
Contribution of CBD to knowledge, attitudes and use of family planning	Compare areas with and without CBD for: # Source of first and most FP information; # Approval and spousal approval of FP; # Intention to use within and beyond 12 months; # Prevalence of current use, by source and method	Catchment and control area KAP surveys; re-analysis of existing data
Effectiveness of alternative CBD models	# New acceptors / CBD; # Revisit clients / CBD; # Effective referrals / CBD; # Other contacts / CBD; # CYP / CBD	CBD program records
Cost of alternative CBD models	Disaggregate cost of each CBD program by: # adminstration; # service delivery and IEC; # supplies; # supervision and support	CBD program records
Efficiency of alternative CBD models	# Cost / CYP; # Cost / new acceptor; # Cost / revisit client; # Cost / effective referral	CBD program records; donor agency records
Contraceptive use dynamics of CBD clients	# Comparison of use dynamics amongst CBD and clinic clients by method: - 12-month continuation rates; - 12-month probability of switching	Retrospective calendar questions; CBD records
Quality of service provided by CBDs	# Comparison between clinical and CBD providers for quality of care indicators	Observation and interviews
Accessibility of service to client	Comparison between clinical and CBD clients for: # Distance/time to nearest supply point; # Hours of service availability; # Cost to client for service and travel	DHS data; catchment and control area surveys
Impact of CBD on STD/HIV awareness	# Source of first and most information on STDs/HIV; # Level of knowledge of STDs/HIV, by source of most information; # Referral by CBD for STD/HIV enquiries	Catchment area survey
Impact of CBDs as reproductive health agents	Type and level of interaction between community members and CBDs for: # Antenatal / postnatal maternal health issues; # Breastfeeding, immunization and child nutrition; # Sexuality; # Infertility; # Unwanted pregnancy	Catchment area survey; CBD interview

Appendix

DISTRICT	NAME OF AGENCY	NUMBER OF CBD AGENTS	POPULATION PER CBD AGENT
NYANZA			
Kisii / Nyamira	FPAK MOH/GTZ	54 781 835	1,362
Siaya	MYWO FPAK MASENO WEST	95 32 400 527	1,213
South Nyanza / Homa Bay / Migori	MOH/GTZ MYWO CHAK AMREF	1,756 161 15 52 1,984	538
RIFT VALLEY			
Trans-Nzoia	FPAK	75	5,249
Kericho / Bomet	FPAK CHAK	45 50 135	6,674
Nandi	MYWO FPAK	112 44 156	2,780
CENTRAL			
Muranga	MYWO	162	5,297
Kiambu	CHAK FPAK	106 30 136	6,724
Nyeri	CHAK FPAK	85 45 130	4,671
Kirinyaga	MYWO FPAK	110 27 137	2,858

WESTERN			
Bungoma	MYWO MOH/KEN-FIN	173 224 397	1,711
Busia	FPAK MOH/KEN-FIN	31 282 313	1,283
Kakamega / Vihiga	MOH/GTZ MOH/KEN-FIN MYWO FPAK CHAK	1,501 665 166 108 46 2,486	589
EASTERN			
Kitui	MYWO	116	5,626
Machakos	MYWO FPAK AMREF	55 45 505 605	2,317
Meru / Maua	FPAK CHOGORIA CHAK	45 403 64 512	2,236
Embu	MYWO FPAK	86 32 118	3,137
COAST			
Taita Taveta	FPAK	61	3,398
Kwale	FPAK	36	10,640
Kilifi	FPAK	70	8,456

Note

To calculate the ratio of population per CBD agent, the 1989 census figures were used. Since then, there has been a reorganization of districts and thus some districts in the table are combined to reflect the population as measured during the census. The Central Bureau of Statistics is currently reanalyzing the data to produce figures for the new districts.