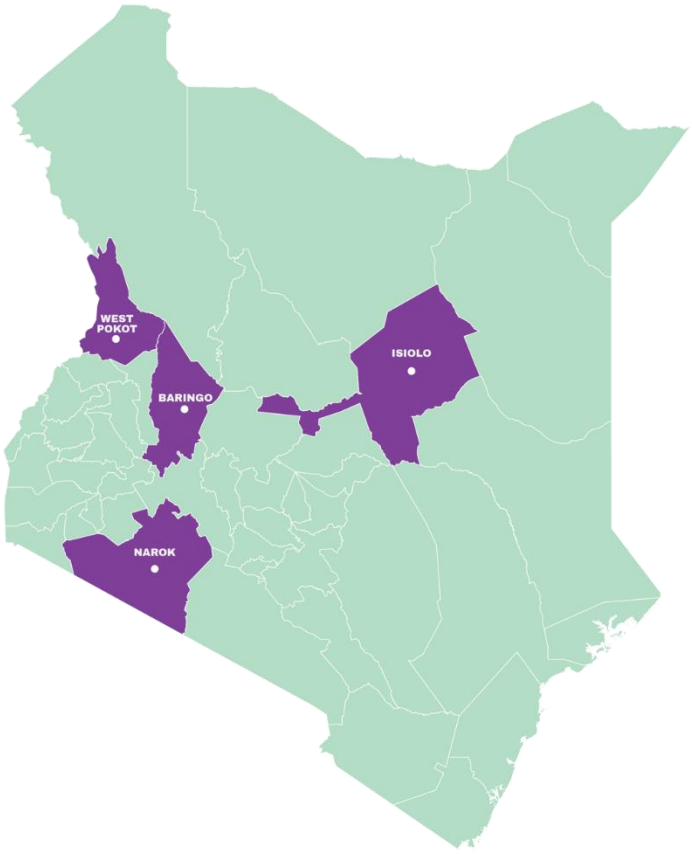
Sustained availability of family planning commodities to the last mile using the Community-Based Distribution model: Experience from the DESIP programme in West Pokot, Baringo, Narok, and Isiolo counties in Kenya

Background: The Community-Based Distribution (CBD) model was critical in promoting access to Family Planning (FP) information and services targeting underserved and hard-to-reach communities in West Pokot, Baringo, Narok, and Isiolo counties in Kenya.



Population Services Kenya (PS Kenya), through the FCDO-funded Delivering Equitable and Sustainable Increases in Family Planning (DESIP) programme, used the CBD model to address equity concerns, complementing other government and private FP services to address barriers to and increase the availability of FP services and commodities among individuals in rural areas and hard-to-reach communities, focusing on rural women of reproductive age, including rural adolescents, poor women (living on <$1.90/day), and Persons with Disabilities (PWDs) in West Pokot, Baringo, Narok, and Isiolo counties. The target counties are characterized by regional vastness, poor road networks, limited health facilities, an inadequate number of healthcare workers, and recorded poor health indices characterized by huge disparities in unmet Family Planning (FP) needs and a fertility rate of 4.1% compared to the national average of 3.9% in 2014. The programme leveraged lessons learned from the initial CBD pilot in Tharaka Nithi County in 2009, which contributed to the amendment of the National Family Planning Service guidelines to permit the provision of injectables such as the Depo-Medroxyprogesterone Acetate (DMPA) by trained community health workers in underserved/hard-to-reach areas. PS Kenya assessed how the linkage of community-based distributors to health facilities influenced the uptake of long-acting reversible contraceptives.

Methodology: PS Kenya piloted the CBD model between 2021 and 2023, first in West Pokot County and subsequently rolling out to Baringo, Narok, and Isiolo counties. Using a phased approach, the programme developed a selection criterion for Community Health Promoters (CHPs) in collaboration with the Ministry of Health (MoH), Division of Reproductive Health (DRH), which included CHPs already trained and with basic literacy levels, community-appointed/approved, ability to engage communities, and interest in volunteer work. The CHPs were identified from Community Units (CU) from hard-to-reach areas in the target counties, trained as CBDs by undertaking a 3-week intensive training, assessment, qualification, certification, and attachment to a health facility. Further, the CHPs were taken through short-term FP services provisions such as condoms, pills, and injections at household levels, referral skills for long-term FP services to health facilities, community engagement, and effective male engagement strategies as a pioneer for FP uptake. Then, CBDs conducted sessions through women's groups, chiefs' Barraza, and community forums, emphasizing reaching out to men who are key decision-makers in child spacing and adopting other related health behaviors around Maternal and Child Health (MNCH). The programme provided FP methods flip charts and FP methods sample bags, DESIP branded T-shirts, bags, and kangas for visibility and identification of the CHPs.



Each CHP attached to a link health facility supported reporting and obtained FP refills from the attached facility through the FP nurse in charge. The programme supported the Sub County Health Management Team (SCHMT) in providing supportive supervision to the CBDs to ensure quality services. The programme targeted women between 15 and 49 years old.

Results: Across the DESIP programme target Arid and Semi-Arid (ASA) counties, including West Pokot, Baringo, Narok, and Isiolo, there was low uptake of long-term and short-term FP methods, despite the high numbers of counselled women between the ages 15 – 49years old on FP methods owing to cultural barriers, the mobile nature of the communities, largely pastoralists, and high rates of insecurity. For the period 2021- 2023, Baringo, West Pokot, and Narok counties had high uptake of short-term FP methods, i.e., Combined Oral Contraceptives (COCs), Progestin Only Pills (POPs) and DMPA Injections among women 15 - 49 years, unlike Isiolo county, which had the highest uptake of long-term FP methods, the one-rod implant (Implanon). Notably, inadequate financial support to sustain CBD stipends contributed to a high CBD attrition rate, contributing to low uptake of FP services across the target counties among women 15–49 years old.

Conclusion: CBDs play a crucial role in ensuring increased access to and availability of quality FP services, especially for adolescents, people experiencing poverty, and PWDs in marginalized and underserved communities. DESIP programme results provide key learning that builds on the government of Kenya's FP2030 commitments of increasing budget allocations for FP services, developing and implementing policies that improve the quality of services, and strengthening partnerships with both the public and private sectors.

The programme addressed key barriers identified during implementation, including supporting advocacy work in the target counties to increase resource allocations for FP service delivery, including resource allocations for CBD stipends to mitigate CDB attrition, which affected FP services; provided technical assistance to the counties on forecasting and quantification of FP products to minimize stockouts and strengthened coordination between the counties and the Kenya Medical Supplies Authority (KEMSA) through training the County Health Management Teams (CHMTs) on the Logistics Management Information System (LMIS) and Commodity Early Warning and Alert System (CEWAS) for improved tracking of FP commodities within facilities.

Notably, key lessons from the programme include the following: It is critical to engage the government (across all levels - national, county, and sub-county), health facilities, and communities from programme design, planning, and throughout implementation to foster accountability, ownership, commitment, and sustainability; CBDs significantly bridge the access gap for FP services among PWDs. They support the identification of PWDs, work with CHMTs to integrate the recording of PWDs in need of FP and Sexual Reproductive Health (SRH) services, facilitate the provision of needed FP services, and strengthen referrals to health facilities for the PWDs, and CBDs model supportive gender norms and behavior as a reference for others. A case in point, the male partners of female CBDs under the DESIP programme shared information with their peers on the benefits of child spacing and encouraged client visits in the home. The integration of male CBDs also opened avenues for greater engagement with other men, for instance, during traditional ceremonies, including circumcision initiation and crowning of elders.

Although these results are limited to four counties, they provide information and experience in implementing the CBDs model in the ASAL context. Therefore, the results can be used to contextualize and scale up the model to additional counties in Kenya alongside other healthcare and development priorities.

Recommendations: Furthermore, key recommendations include CBD models to ensure the incorporation of both classroom and clinical placements of the community-based distributors for practical and hands-on experience engaging clients; it is critical to engage all the key stakeholders, including the health sector actors, local authorities, political leaders and municipal functions, and community members in the planning and implementation process. Effective and active participation through community mobilization is essential for success; continuous refresher training during monthly CBD meetings increases competencies and retention of knowledge among the community-based distributors; inclusion of link-facility staff in routine data quality assessments and supervision enhances the quality of CBD services, complemented with provision of ad hoc training on identified skills gaps of the staff; build the capacity of the counties to use data for evidence-based decision-making on CBD activities, as well as their inclusion in the sub-national health budgets and annual work plans as a best practice; strong collaboration and engagement with communities, including during community dialogue forums increase awareness and utilization of CBDs as a trusted source of SRH information and FP services and products. Creating a virtual community of practice at the national level facilitates continuous learning and sharing. Future interventions and research can provide findings on the effectiveness of the CBD model in different contexts for cross-learning and continuous improvement towards addressing barriers to and increasing access to quality, affordable, and accessible FP services.

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