

ACQUIRING KNOWLEDGE

Applying Lessons Learned to Strengthen FP/RH Services

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The AMKENI Model

Learning Global Lessons from Improving Family Planning, Reproductive Health, and Child Survival in Kenya

Introduction

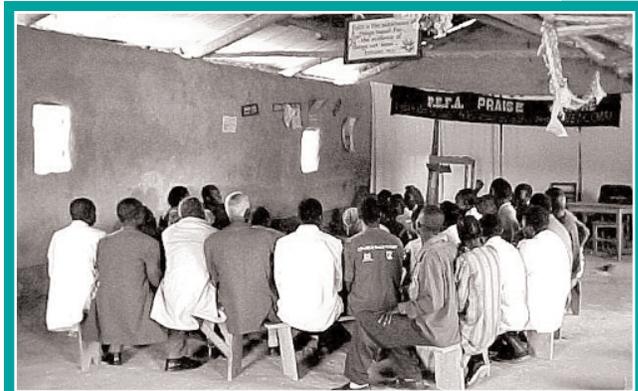
From January 2001 to June 2006, the AMKENI Project worked with the Kenyan Ministry of Health (MOH) in Coast and Western Provinces to increase the use of reproductive health (RH), family planning (FP), and child survival (CS) services at the community level. A partnership of EngenderHealth, Family Health International (FHI), IntraHealth International, Inc., and the Program for Appropriate Technology in Health (PATH), AMKENI was funded by the U.S. Agency for International Development (USAID).

Working to build and strengthen sustainable, integrated, and comprehensive RH/FP/CS services, AMKENI collaborated with the MOH on policy reform, systems development, and capacity building. AMKENI also worked to engage and strengthen existing MOH and community structures. At 97 public and private facilities in 10 districts, the project developed the capacity of local health providers to deliver a wider array of quality RH/FP/CS services. And the project mobilized youth, men, women, and families in nearly 400 communities to practice healthier behaviors and increase their use of these services.

AMKENI's comprehensive model, which links supply and demand through coordinated facility-based and community-based activities, was adapted for use in the ACQUIRE Project's programmatic approach. ACQUIRE worked with AMKENI to document their strategies, successful practices, and lessons—the objective being to identify, utilize, and scale up best practices from a bilateral project through a global project.

Approach

The AMKENI Project's approach was distinguished by its dual focus on decentralizing services to lower-level facilities—dispensaries and health centers in addition to district hospitals—and on fostering community empowerment and a supportive environment for individual and community change. To make services more accessible and



Village health committee meeting

“AMKENI is different because it takes a grass roots approach. It’s like a light on the hill; it [shines] out to all the people. It finds out what people want and helps them solve their problems.” —Village health committee member

responsive to clients, training and supervision functions were also decentralized. This innovative, integrated program design linked health facilities and their support systems to their communities, fostering self-reliance and sustainability.

AMKENI implemented three strategies in working toward its goals: improve the capacity of health facilities to provide quality RH/FP/CS services, including HIV-related services; work with communities to enhance healthier behaviors and demand for RH/FP/CS services; and strengthen the MOH's policies and decentralized systems for training and supervising RH service providers.

To ensure that improvements to services at the district and community levels were sustainable and could be replicated throughout Kenya, AMKENI worked with the MOH to facilitate the initiation of a decentralized Reproductive Health Training and Supervision (RH T&S) system. This system was designed by the MOH to first create and then maintain high-quality training and supportive supervision teams at all administrative levels of the MOH.

To expand and strengthen service-delivery capacity at the health facility level, AMKENI supported a broad range of interventions at both public- and private-sector facilities. Activities included: upgrading infrastructure and providing essential medical equipment; enhancing health workers' technical knowledge and skills; improving the service-delivery environment (i.e., infection prevention, water supply, waste disposal); improving resource materials, such as job aids; improving staff supervision; providing client educational materials; initiating syndromic management of sexually transmitted infections (STIs), voluntary counseling and testing (VCT) for HIV, and prevention of mother-to-child-transmission of HIV (PMTCT); integrating HIV services with other RH services; introducing self-improvement tools and management committees for quality improvement; and supporting community outreach services.

AMKENI's behavior change communication (BCC) strategy worked with communities around the targeted health facilities to increase demand for services, foster women's empowerment and participation in RH/FP decision making, and promote healthy behavior. A hallmark of the AMKENI approach was to engage the community surrounding each facility to put people "in the driver's seat" for bringing about desired change.

AMKENI mobilized 754 villages to form village health committees or health facility management boards. More than 2,218 volunteer field agents were trained to provide information and mobilize community involvement in RH/FP. Approximately 51,000 members from over 2,700 community groups were engaged in regular BCC activities, reaching more than 2.8 million people.

To access people living in the more distant and isolated sections of the catchment areas of supported health facilities, Health Action Days were organized in the communities themselves. In addition, to counter staff shortages and facilitate the attendance of women, "Mothers' Days" were held at the health facility. At these events, extra staff from neighboring facilities and community volunteers would work together for the day. The management and organization of these days was done by both community groups and health facility staff. AMKENI also facilitated "in-reaches" at its supported health facilities, bringing in doctors and supplies to provide RH services that are not usually available, such as bilateral tubal ligation and no-scalpel vasectomy. The community promotion and support made these events extremely popular.

Women have potentially the greatest impact on protecting and improving the health of their families, yet they often lack the power and authority to make these decisions. By working with the community and by promoting and advancing women's involvement, AMKENI developed the capacity of women to play their rightful role in all community activities. For example, a Peer Families program provided a forum for wives and their children to voice their needs and concerns in a supportive environment. In addition, AMKENI ensured that women were equitably represented and had a voice on the health facility management boards and village health committees.

"Health workers now are friendly and helpful. They want to know what my problems are. As a result of their better attitudes, more people are going to the clinics."—Client

Results

AMKENI's achievements have had a significant impact on the access to, quality of, and use of RH services in the Coast and Western Provinces. People now can choose from an increased range of FP methods, and more are using more methods. At the baseline, most facilities could only offer short-term methods, such as the pill, injectables, and condoms, and the number of clients was low. AMKENI enabled the facilities to provide a range of methods, strengthening the capacity to provide long-acting and permanent methods (LAPMs) in particular. For example, the number of facilities that could provide IUDs rose from 5% at baseline (2001) to 35% by the end of 2005, and reported IUD insertions rose from 510 in 2001 to 1,169 in 2005. During the same time period, acceptance of all LAPMs rose by 152%, and the number of new FP users increased by 65%.

In late 2000, the MOH changed its policy to allow nurses and clinical officers to provide postabortion care (PAC) and implant insertion and removal services. AMKENI wholeheartedly supported training for these cadres in the supported districts: For implants, they further assisted the MOH in a nationwide training program in 2002. For the first time, these services became available at health centers and dispensaries. Between 2003 (the baseline year for PAC attendance) and 2005, the annual number of PAC clients served increased by 43%—from 1,614 to 2,304.

AMKENI strengthened safe motherhood services and greatly increased the number of deliveries occurring in health facilities. After the provision of training in essential obstetric care as well as of maternity beds, delivery

LESSONS LEARNED

- **It is important to ensure that quality services are available before initiating activities to increase demand:** Demand and supply should be coordinated carefully. If health promotion in the community precedes the initiation/ expansion of services, the community may be disappointed in the results.
- **Collecting baseline data on services in a timely manner is very important:** These data can be used not only during the planning phase, but also at later stages in the project to check progress. Baseline data for AMKENI were not collected at the initiation of the project, and data from the first year of implementation had to be used as the baseline.
- **Dynamic management leadership at the facility level is an important factor for bringing about major improvements:** Implementing change requires strong commitment and leadership at the managerial level. Annual AMKENI internal assessments showed that poor health facility leadership can mean that little improvement takes place, regardless of the other inputs made.
- **Continued clinical and managerial training for health workers is critical:** Staff turnover can be high, and new recruits often lack the necessary clinical skills needed for the new and upgraded services being offered at health centers and dispensaries. Management, counseling, and stigma reduction skills may also be in high demand.
- **Privacy and confidentiality with respect to VCT and PMTCT are major concerns:** Stigma and discrimination deter people from seeking and accepting HIV/AIDS services. Given the small, crowded environments of most low-level health facilities, minor renovations and infrastructure improvements may be needed, and this work can cause delays in the initiation of services.
- **Programs must seek and respond to the expressed needs of community members:** When programs also help people to address their most pressing concerns, the people become more open to listening to and accepting FP messages and services. Linking health workers and communities to other resources is an effective strategy for addressing these needs.
- **Despite advances in gender equity, men are still the primary decision makers in all matters, including RH/FP:** Increasing men's involvement in and knowledge of RH is a critical factor to improving services and service attendance. Approaching and involving the rural male in health education and promotion is difficult. Linking with projects in other sectors, such as agriculture, could provide a larger base of existing male groups and increase impact.

beds, and delivery packs, the number of facilities capable of conducting deliveries rose from 64 to 90. The total number of normal deliveries at the facilities increased dramatically between 2001 and 2005—from about 15,100 to more than 27,700.

In 2003, AMKENI expanded its HIV/AIDS interventions, strengthening VCT and PMTCT services where they existed and initiating services at selected health facilities as part of the President's Emergency Plan for AIDS Relief (PEPFAR) program. Both services were popular, and health workers were often unable to meet the demand, due principally to the shortage of HIV test kits, nevirapine, and staff, all of which were beyond AMKENI's control to improve. However, despite these challenges, 98,480 antenatal clients received HIV counseling and testing at the 85 AMKENI-supported facilities offering PMTCT services since 2003. And more than 127,000 VCT clients at 79 AMKENI-supported facilities have received their test results since 2003.

Impact

AMKENI achieved its objectives: It not only made an important difference in access to, quality of, and use of RH/FP/CS services in project areas in Kenya, but also in the relationship between health care facilities and the communities they serve. It also left a legacy of proven strategies and lessons with global implications.

AMKENI staff formed a true partnership with MOH staff, jointly planning and implementing projects. MOH staff members report that AMKENI was unique, in that the project worked with and strengthened existing ministry and community structures. The RH T&S system was initiated in all 10 provinces and was piloted successfully down to the health facility level in two districts; the MOH intends to roll out the system nationwide.

By the end of the project, each province in Kenya and the 10 districts within the AMKENI Project area had RH T&S team members who had been updated in their clinical skills, exposed to supportive supervision procedures, and instructed in clinical training skills and on-the-job training techniques. The project also included preservice trainers from various Kenyan Medical Training Colleges in its training support. This assistance created a large reserve of high-quality, local experts in training and in supervision.

A successful approach to introducing expanded, strengthened, or new services in health facilities was whole-site orientation and training, which updated all members of the staff on the protocols. And in addition to clinical and management training, efforts were made to improve the attitudes and interpersonal skills of health workers and their supervisors. Health workers are now more confident in providing services and supervisors more confident in

Best Practices

Service delivery (*supply*)

- Implementing quality improvement approaches—such as the performance improvement approach, facilitative supervision, and COPE® (which stands for client-oriented, provider-efficient services)—to improve the knowledge, attitudes, and skills of providers
- Conducting whole-site training
- Decentralizing training and supervision
- Linking health facilities to communities

Community engagement and agency (*demand*)

- Fostering MOH and community ownership
- Promoting community and women's empowerment
- Facilitating mothers' days, health days, and other outreach events
- Using community peers (peer families, child-to-child)

their supervision. Community members have pointed out that AMKENI's most important impact was the improved attitude of health workers. One simple but notable comment by a nurse summarizes this change: "I now look at patients as people, not as cases."

The village health committees and their communities have developed a sense of ownership of and responsibility for their local health facilities and outreach services. An unanticipated result of the AMKENI Project is that communities have taken the initiative to adapt the AMKENI approach to address pressing community concerns unrelated to RH/FP. During community self-assessments, the village health committees decided to gather information on people's other priority health needs, in addition to RH/FP. They then developed and implemented two action plans, an RH action plan and an action plan for other health issues, such as clean water and malaria. AMKENI volunteers realized that such issues were extremely important to the communities, and they linked the community groups to other donors or local agencies that could work with them in addressing these problems. By implementing both plans, the village health committees built the trust and confidence of their communities and helped ensure their own long-term sustainability, as well as that of RH/FP services.

The AMKENI Project is widely known and respected throughout the targeted communities. Community members believe that the project has had a positive impact on their health. AMKENI's community mobilization activities were so successful that 386 communities that did not initially decide to join in project activities later approached AMKENI staff and community workers to

request assistance in setting up parallel organizations and activities in their own villages. AMKENI could not fully assist these communities because of time and funding constraints, but it supported these replication efforts by building the capacity of an additional 878 field agents.

AMKENI best practices live on, with the ACQUIRE Project utilizing lessons learned from AMKENI in its current programming. AMKENI reaffirmed the importance of linking site-level providers to the larger community, and ACQUIRE closely collaborates with health ministries throughout Africa to strengthen these linkages. In Kisii, Kenya, for example, with support from ACQUIRE, the MOH held community linkages meetings to bring together providers and community members. These meetings provided an opportunity for community members to express their concerns regarding family planning services and for providers to meet the community volunteers engaged with the project. In Ghana, "champion" nurses engaging in an MOH/ACQUIRE-supported vasectomy initiative continually reached out to the community by distributing information, education, and communications materials at marketplaces during their off hours. Strengthening the linkages between the service-delivery site and the community fostered increased communication and understanding. While the AMKENI Project may have ended, its impact continues.

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