



Theme:  
Innovations in RH Service  
Provision: OBA Project

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# Voucher Babies: RH Project's Remarkable Success

By David Kinyua and Josiah Mwangi



*German Ambassador to Kenya holds a baby delivered through the OBA Voucher system during project tour*

**An ingenious** pilot project that aims to improve access to reproductive health services among the underserved has produced notable results since it was launched in June 2006. Through the project dubbed the Reproductive Health – Output Based Approach Project (RH-OBA), over 39,000 women have been able to deliver healthy babies while about 5,000 clients have been provided with other reproductive health services.

The RH-OBA Project is a joint venture between the Government of Kenya (GoK) and the Federal Republic of Germany. An agreement to undertake the project at a total cost of Euros 6.579 million was signed between the two parties on 7th March 2005. Funds to finance the project are largely provided by the Federal Republic of Germany through KfW Bankengruppe. The Government of Kenya is also providing some funds to the Project.

The objective of this three year pilot venture is to improve

access to quality reproductive health and family planning services through a voucher system for the economically disadvantaged people living in Kisumu, Kitui, and Kiambu districts as well as Viwandani and Korogocho slums in Nairobi. In addition, the project covers the cost of providing gender based violence recovery services to this target group.

The OBA Project is expected to contribute to a reduction of both maternal and infant mortality rates that currently stand at 414 per 100,000 live births and 77 per 1,000 live births respectively at national level. More importantly, lessons learnt from the project are expected to inform the anticipated National Social Health Insurance Scheme. ■

# From the Chief Executive Officer



Dr. Boniface K'Oyugi,  
CEO, NCAPD

The National Population Policy for Sustainable Development aims at guiding the efforts of Kenyans and our international friends to improve the well being of all Kenyans. The policy recommends action areas in matters of

fertility, migration and mortality, especially reduction of deaths among women in reproductive health age and infants.

Success of the population policy would be achieved through building partnerships and careful management of concerns antecedent to attainment of this policy goal. In addition to leading in the formulation of population policy, the National Coordinating Agency for Population and Development - NCAPD acts as a catalyst by initiating projects aimed at addressing specific population concerns. This issue of Kenpop highlights the Output Based Approaches (OBA) project as an innovation in financing reproductive health services. The project aims at reversing the low uptake of reproductive health services by the poor in selected pilot sites. When the first phase of this pilot project comes to an end in a few months time, several key lessons will have been learnt. Already the project, which according to articles carried in this newsletter is a success, has encouraged more women to deliver in health facilities thereby reducing health risks. OBA has demonstrated that it is possible to maximize impact of funds invested to achieve MDGs and reduce inequity in reproductive health service provision.

Although implementation of OBA project is not without challenges, the bottom-line is that the poor deserve targeted intervention. And when this intervention comes in a critical area as reproductive health, the support of everyone interested in population and development programmes is called for as focus shifts to scaling up of the OBA project in the country.

## Editorial Desk

This issue of Kenpop Newsletter brings out clearly the need for targeted interventions to ensure the poor access reproductive health care. However questions pop-up about the poor's contribution to their own welfare.

Research for example shows that when men are involved and the right decisions are made on time, women's and infants' lives are saved. This is cheap for everyone.

As you read through these articles we welcome you to share ideas through this publication on how to ensure access to reproductive health care to all sustainably.

David Kinyua

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Kenya Media Network on Population and Development

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# Fertility planning hits town:

## OBA Project Outcomes in Kisumu, Kiambu and Kitui

By Kenpop Team

**At the Marie Stopes** Nursing Home in Kisumu town, relatives wheel in a pregnant woman in labour pains and hand over a card marked 200 to the receptionist at the counter. The woman is admitted at once without any questions.

The card is a voucher that allows her access to maternity services in any public, mission, or non-governmental hospital, which is accredited to accept such vouchers. The card is known as Safe Motherhood Voucher and costs Ksh 200. The card is an assurance. In real terms, it allows a woman to spend up to Sh 21,000, money paid by project. This voucher scheme in Kenya is expected to increase access to quality delivery services to poor women. Once a woman has a Safe Motherhood Voucher, she is entitled to all maternity services that ensure safe motherhood - caesarian section, emergency obstetric care, delivery and postpartum care.

Upon delivery, she is again introduced to another voucher-the Family Planning voucher which costs Ksh 100 and entitles the woman access to long term family planning services of her choice i.e. implants, IUD, both male and female vasectomy, and counseling in facilities where this is available. Another important service provided by the voucher scheme is the Gender Based Violence Recovery (GBVR) services. No voucher is required to access these services and GBV clients from the project sites are entitled to medical examination, treatment and counseling under this arrangement.

The International Planned Parenthood Federation Africa Region (IPPFAR) in their Magazine "AFRICA LINK", notes that Uganda is implementing an OBA voucher scheme that helps couples to access STI treatment and counseling services with similar success.

The voucher system is an innovative way of encouraging poor women to deliver in health facilities and enjoy other reproductive health services using support from development partners.

Under this approach, the Reproductive Health Output-Based Approach (RH-OBA) beneficiaries have to meet a strict poverty criterion. It operates on the principles that financing agreed-on outputs with pre-defined quality rather than pre-defined inputs is the best way to maximize on use funds. It is a strategy used to finance projects through explicit performance-based subsidies to support the delivery of basic services.

Accredited facilities may be either private, public facilities, NGOs or Community Based Organizations. These service providers are selected on the basis of qualification; among other criterion they should have been in operation for at least three years and approved by government, before being allowed to accept and make claims against the vouchers. The RH-OBA approach tends to avoid the traditional approach of funding a budget or inputs long before actual services are delivered. It contrasts with input based approach, which may be poorly targeted leading to wastage of funds in non-profit areas.

"What this approach does is to encourage service providers to invest in services which the community feels are priority to them," says Dr.K'Oyugi, the CEO, National Coordinating Agency for Population and Development the organization coordinating the initiative. "It further encourages provision of quality services since a service provider who offers low quality services face losing clients," he adds. It is also believed with this approach, the private sector will invest in rural areas where health services are limited or non-existent.

*Cont'd on pg. 4*



*Mother and baby relax after leaving delivery room*

from pg. 3

The implementation of the OBA pilot project was born out of the need to reduce the current high maternal mortality rates. The last Kenya Demographic and Health Survey (KDHS 2003) reported that in Nyanza province over 60 percent of women did not access skilled reproductive health services and therefore deliver at home, which exposes them to many health risks including death.

Kisumu district has eight OBA accredited facilities that offer both normal and caesarean section methods of delivery. These accredited facilities, however, are concentrated in the urban areas with five in the city, two in the rural and one in the peri-urban areas.

According to the Kisumu Provincial Medical Officer's office the number of women who delivered in health facilities under skilled assistance since the commissioning of the OBA project in 2006 has steadily increased. It is now estimated that this number has more than doubled especially among the poor who hitherto could not afford delivery services in health facilities. This is bound to improve even further if current trends boosted by OBA project continue.

Recent spot checks by Kenpop Teams in various project sites revealed quite interesting results. In Kisumu the Marie Stopes Clinic, which is an NGO private facility, is almost exclusively serving OBA voucher holders while some accredited government facilities are said to be losing even the few customers they were serving before the start of the project. However at the Kisumu district hospital, satisfied mothers cuddled their babies while nurses enjoyed their work using new equipment bought using incomes generated through the OBA project. The Hospital Administrator hopes the government would complete the hospital extension under construction to ease the congestion at the maternity ward.

At the Marie Stopes Clinic the Kenpop Team was shown newly constructed extension to existing buildings and additional beds

bought by incomes generated from the OBA project. The Hospital Manager while appreciating the phenomenal impact of OBA to their business is quick to add that the hospital had embarked on aggressively marketing its services in order to continue attracting fee-paying customers. Like all other actors in the OBA project the Kenpop Team interacted with, the manager is concerned with sustainability of the good brought about by the OBA project.

During an interview with the proprietor of Milimani Hospital, another accredited facility that borders Nyalenda slums, it is clear, where OBA is operating services have taken a different impetus. In contrast to the facilities operated by government or the NGOs the experience of a private hospital with OBA is remarkably different. Poor women for example, are now more empowered, and attend hospital more times than usual. In addition to reproductive health services pregnant women are presenting the OBA vouchers for all manner of ailments quite often unrelated to pregnancy.

Since Kisumu is prone to malaria accredited private hospitals have had to attend to women when they show symptoms of the disease. Fortunately there exist excellent arrangements for sharing health resources in the district. The doctor in charge alluded to the sharing of emergency facilities including ambulances. The referral system also works. But her headache is when dealing with voucher clients with complications when decisions have to be made very fast in order to save a life. In such circumstances costs escalate beyond the OBA allowable limits. She argues that it costs more per unit of service in commercial private hospitals than in Government and NGO facilities which are ordinarily subsidized adding that OBA should consider varied service costing putting the price range between Ksh.35, 000 and 55,000 for the more complicated RH care at private hospitals.

When Kenpop Team visited Kisumu, it was observed, the safe motherhood voucher is generally a success. But the family planning service had not picked up as fast, something blamed

on erratic supplies of preferred methods of contraception. Low uptake of gender based violence recovery service was also noted. However expectations of the target community were that the project would cover even a wider area and benefit more people. Though service providers too are happy they are anxious that the project that has come to help the poor would end without alternative financing mechanism in place.

Observations in the other pilot areas of Kiambu and Kitui are generally similar. However to ensure the right people in Kiambu received vouchers, the RH-OBA team had first to map out 39 poverty sites and then used these as guide and applied the Poverty Grading Tool to identify the most needy hence deserving OBA Voucher clients.

Uptake of the safe motherhood voucher like in other areas has been good in Kiambu. Kijabe Mission Hospital, which is located in the project site, has built a new maternity unit, a newborn facility and purchased an ultra sound machine with proceeds from the project. As for Government health facilities, there has been a noted decline in the number of fee waivers to poorer clients.

In Kitui, OBA is a welcome relief to the poor who have had to travel long distances for services. Suddenly the poor too can access quality reproductive health care in private and Mission hospitals long believed to be out of reach to lower income clients.

The OBA pilot initiatives definitely have lessons to use in the anticipated scale up of safe motherhood interventions and provision of family planning services under the envisioned National Social Health Insurance Scheme.



*Manager, Marie Stopes Nursing Centre Kisumu explaining a point*



*Atieno and her children*

## Atieno's OBA Story

**T**hough only seventeen years old, Atieno, an orphan who lives in Nyalenda slums of Kisumu is already a mother of two. She conceived her first child at fourteen as a result of rape during the burial of her late mother. The second conception came a little under a year after the birth of the first child and a few months after the death of her father. Although this time Atieno knew who was responsible for the pregnancy, the boda boda (cyclist for hire) operator could not afford the support she needed.

Together with three other children Atieno shares their late parent's mud walled house under the watchful eye of an uncle who lives nearby. The uncle though has a family of his own and therefore constrained to support Atieno and her siblings.

Atieno narrated to a visiting Kenpop team how she met Rose, the OBA Field Educator after being introduced to her by neighbours. Rose had explained to her the benefit of acquiring the OBA Vouchers. Although the uncle assisted, so touching was Atieno's story that even the OBA Field Educator contributed KShs. 100 to buy the vouchers for Atieno. This is a typical case of OBA project beneficially.

# NCAPD gets a new CEO



*Dr. K'Oyugi flanked on both sides by the Permanent Secretary and Economic Secretary - Ministry of Planning parades his NCAPD team during a recent ministry staff-bonding event held at the Bomas of Kenya*

**Dr. Boniface** O K'Oyugi was appointed Chief Executive Officer of NCAPD with effect from July 2007. The Minister of Planning & National Development announced this appointment in Gazette Notice no. 6919 of 20th July 2007.

Prior to his appointment, Dr. K'Oyugi was a senior lecturer at the Population Studies and Research Institute of the University of Nairobi. He has a wealth of experience in population research and development issues in Kenya.

Dr. K'Oyugi is a demographer with a PhD in Population Studies from the University of Nairobi and a career public officer having started work at the Ministry of Planning and National Development in the 80s.

## Kenya National Survey on Persons with Disabilities Conducted

**The first Kenya** National Survey on Persons with Disabilities (PWDs); was conducted between July and November 2007 at a cost of Kshs 80 million. The survey objectives were to estimate the number of PWDs; examine the demographic, socio-economic and socio-cultural characteristics of PWDs; determine the nature, types and causes of the disabilities; identify specific problems faced by PWDs, their coping mechanisms and needs; and to establish the nature of services and rehabilitation programmes available for PWDs.

Data was collected from 15,000 randomly sampled households in 600 enumeration areas throughout the country over a period of 4 months. The NCAPD and the Kenya National Bureau of Statistics (KNBS) in collaboration with the National Council for Persons with Disabilities, the Department of Gender and Social Services, the Ministry of Education, the United Disabled Persons of Kenya and the Kenya Programme of Disabled Persons are implementing this survey. Other partners include The Association for the Physically Disabled of Kenya, the International Development Programme and Ministry of Health.

The Department for International Development (DfID), the United States Agency for International Development (USAID), and the World Bank provided funding for the survey.

## First Kenya AIDS Indicator Survey Conducted

**Between July** and November 2007, Kenya carried out the Kenya AIDS Indicator Survey (KAIS) aimed at tracking progress made in achieving the government's targets set out in the HIV and AIDS Strategic Plan as well as the goals of the United Nations General Assembly Special Session on HIV and AIDS - UNGASS.

Fieldwork was carried out between July and November 2007 and the final report will be released to the public by August 2008. Specifically, KAIS collected information on knowledge and behaviour data relating to HIV and AIDS and other sexually transmitted infection and the prevalence of HIV, syphilis and herpes simplex-2 (HSV-2) among women and men.

The survey, which cost about US \$4 million is funded by PEPFAR and UNAIDS while the National Aids /STD Control Programme (NASCO) is the main implementing agency. Other institutions collaborating in the survey include the Kenya National Bureau of Statistic, the National Public Health Laboratory Services, the National Coordinating Agency for population and Development and Kenya Medical Research Institute, the National AIDS Control council, Centre for Disease Control and Prevention Centers (CDC) and USAID.

## 2004 Kenya Service Provision Assessment: Further Analysis Conducted

**To get more** insight into issues raised by the 2004 Kenya Service Provision Assessment (KSPA), the NCAPD with the technical support of Macro International identified investigators from, academic and public institutions to conduct further analysis to inform policy on the quality of health service provision. The KSPA was intended to assess the preparedness

of health facilities in Kenya to offer quality health services in areas that included maternal health, child health, HIV/AIDS, Services to the youth, PMTCT, and Management Issues.

Apart from the analysis, the process aimed at building the capacity of researchers and institutions in analyzing data to inform policy. The survey findings have been widely disseminated. Preparations are top gear to communicate specific issues to relevant policy makers.

# Coalition-Building for Population, Health, and Environment Integration

By Karugu Ngatia



**The Population** Reference Bureau (PRB) conducted a two-day workshop on coalition building for East African Population, Health, and Environment (PHE) stakeholders in Addis Ababa, Ethiopia from November 12th to 13th 2007.

The workshop drew participants from, Ethiopia, Kenya, Rwanda, Congo, Tanzania and Uganda. Resource persons were drawn from, the Philippines, Madagascar, and the United States of America. PRB and Training Resources Group (TRG) co-facilitated the event. The Conference brought together researchers, PHE practitioners, programmers, and policy makers to examine the status of PHE integration in the Eastern African region. During the conference, country PHE reports for Kenya, Ethiopia and Tanzania were presented.

The conference observed that the PHE approach to development recognizes the crucial link between people and their environment. “Integrating population, health and environment programmes have shown better results than single sector programmes and are more programmatically efficient.” Said Dr. Boniface K’Oyugi the CEO of NCAPD who officially launched the Eastern Africa PHE Network. It was also noted that PHE programmes have lower operating costs hence fostering community goodwill and trust.

More than 150 participants from different countries witnessed the launch of the Eastern Africa PHE Network during the Addis conference.

The vision for the Eastern Africa PHE Network is; “An Eastern African region where men, women and children are healthy, the environment is conserved and livelihoods are secure”; while the Mission is “to provide leadership and create partnership to promote and support the integration of Population, Health and Environment for sustainable development in Eastern Africa”

Members of the Eastern Africa PHE Network are Kenya (the host), Tanzania, Uganda, Ethiopia and Rwanda. At the country level NCAPD will coordinate the activities of the Network.

The Network will be looking at the potential for intensifying, replicating and expanding PHE programmatic approach to different landscapes (urban and rural setting, from a community to an ecosystem approach; across varying landscape such as coastal and upland areas, and to different parts of intervention such as disaster mitigation, poverty alleviation, food security, HIV/AIDS and programming among others.

The Government of Kenya is taking into account the integrated approach in the preparation of the Vision 2030 Medium Term Plan (MTP) 2008-2012.

*Mr. Ngatia is the Programme Manager, Programmes Coordinating, Monitoring and Evaluation at NCAPD.*

## Health Services in Kenya Respond to Crisis

**With over 1,000** people dead and over 300,000 rendered homeless following post election violence, health services in Kenya have been stretched to limit. Critical though are increased reproductive health needs. In particular the rise in the number of reported rape cases in areas hardest hit by the violence, as well as demand for safe motherhood and other reproductive health services in the camps against the absence or limited availability of health personnel, equipment, supplies and facilities and infrastructure for referrals has necessitated an emergency response.

The Division of Reproductive Health at the Ministry of Health has developed a Three Month Work Plan to specifically respond unforeseen needs. Together with other organizations providing health services DRH hopes to strengthen the health response to the crisis. Of key importance was ensuring that displaced people on ARVs kept up with their medication by linking them up with the nearest health facilities.

The Ministry of Health has therefore joined in humanitarian assistance, setting up makeshift emergency health care structures in camps and improving capacity of health facilities neighbouring the camps to be able to respond to the many RH needs of the displaced persons.

The emergency situation is not yet over and the Government and donor partners are still appealing for help to meet the humanitarian needs for all the displaced people.

# Media Lobby on Population Launched

The recently reconstituted Kenya Media Network on Population and Development (KEMEP) was launched in December 2007 at a colorful ceremony at the Stanley Hotel by Dr Edward Sambili the Permanent Secretary Ministry of Planning and National Development. The network, which brings together professional journalists with interest in population and development, commits to informing policy makers and the public about reproductive health, gender news and other pertinent population issues.

Kemep works closely with the NCAPD and development partners working in the field of population. Through the

support of collaborators in particular the United Nations Population Fund (UNFPA) the network has since September 2006 carried out numerous activities to ensure visibility of population issues as they impact on national development.

At the launch nine journalists from the print and broadcasting media were awarded for their excellence in highlighting critical aspects of population and development. Each of the nine winners received a laptop and a trophy.

Other dignitaries, who included the United Nations Population Fund (UNFPA) Country Representative Director of Information and NCAPD Chief Executive

Officer, graced the occasion.

In his speech, the PS noted that the launch of the network could not have come at a better time, as the media would be joining the government in partnership to make the Millennium Development Goals (MDGs), in Kenya a reality. He hoped that the rejuvenated KEMEP would bring population related issues to the fore and elicit public debate. This in itself would show that the media, which is a very effective tool of communication, still plays a crucial role in empowering the people to make choices and take charge of their own development.

## Documentary on Repositioning Family Planning in Kenya

The NCAPD is producing a documentary to support the ongoing joint initiative with the Ministry of Health and several development partners to reposition family planning as a critical issue in Kenya.

Repositioning Family Planning is a multilateral initiative to ensure access to quality family planning services remains a key issue for policymakers and providers working to impact children's health as well as the health of women and men in Africa.

The goal is to mobilize commitment to and strengthen family planning services in Kenya, which will lead to expanded access and help meet women's stated desires for safe, effective modern contraception. Crucial to the success of this initiative are: Increased political commitment, financial and human resources for family planning, strengthened participation and coordination among national leaders, donors, and other partners, including the private sector and a more effective allocation of resources toward technically sound programmes.

The target audience for the family planning documentary is opinion leaders, policy makers, program implementers and managers who are expected to use the documentary to inform and influence decisions on 'repositioning' of family planning in Kenya.

The documentary is being developed with financial assistance of USAID through the Population Reference Bureau.

## East African Reproductive Health Network: Kenya Hands Over Baton

The NCAPD Kenya's PCC for South - South collaboration handed over the East African Reproductive Health Network (EARHN) Desk to Tanzania. EARHN is an initiative of South-South Partners in Population and Development in East Africa. The South-South Initiative was formed by ten (10) developing countries in Cairo, Egypt during the International Conference on Population and Development in 1994. Members have since increased to 21.

Kenya hands the mantle at a time when the Partners in Population and Development idea of "twinning" arrangements where each partner works with at least one other partner country in a two way exchange of experience is maturing in East Africa.

# Output Based Aid: How it Works

By Cynthia Macharia

**Output Based** Approach (OBA) in the health field is a demand side financing mechanism that helps to meet costs of pre-determined outputs. The outputs are usually specific health care services such as provision of family planning services, safe deliveries for mothers or treatment of sexually transmitted diseases.

Financing for these services can be done through various means. Some of the more practical approaches include issuing vouchers or coupons for the service seekers; or making direct payments to service providers for services provided. In the former, the service seeker acquires the voucher (usually by paying a small co-payment) and presents it to the service provider who in turn provides the required service and is later reimbursed for the full cost of the service. Under the latter mechanism, no voucher is required, but the service provider is reimbursed for service provision. Clear definition and costing of the service package is therefore a prerequisite of the reimbursement system hence must be realistic covering

the full cost of service provision, but must not distort the existing 'market'.

OBA provides an avenue for subsidising the cost of health care especially for the economically disadvantaged. The co-payment paid by the service seeker when obtaining a voucher is usually a very small fraction on the real cost of the service required. The service provider on the other hand is reimbursed for the full cost of the service. The difference can either be met by funds provided by the government, or from any other financier in the health sector. To ensure proper management of these funds, a fund managing institution may be required to vet vouchers returned for reimbursement, and to make the payments.

## Financing Outputs versus Financing Inputs

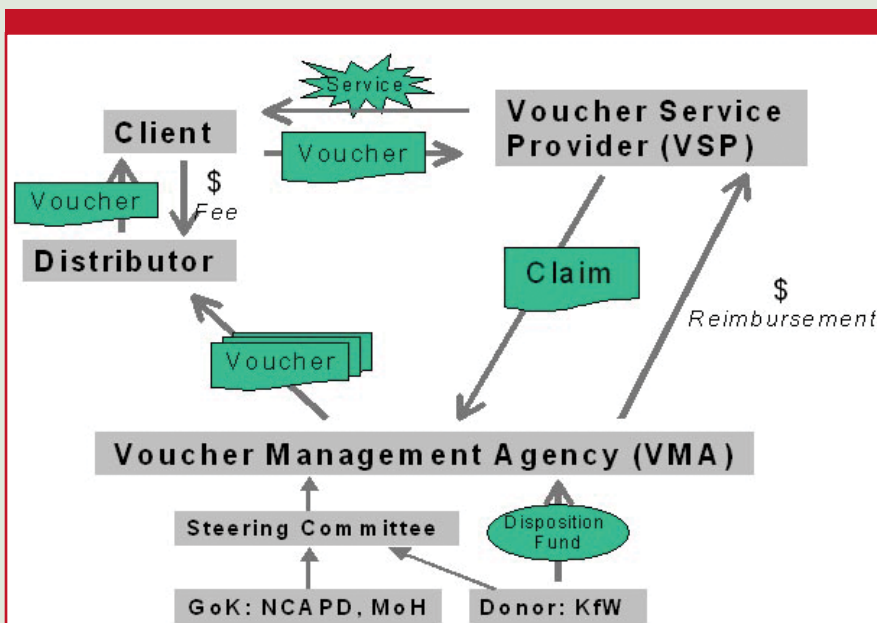
Traditional financing mechanisms in the health sector are mainly input oriented or supply side interventions. This typically involves provision of drugs, equipment, staff remuneration, and infrastructure

and non-medical consumables. The underlying assumption is that with the inputs provided, health care facilities are empowered to provide the services required. Some experts have however queried this approach especially in developing countries where governments may not be able to raise enough revenue to cover the range of inputs necessary for adequate service provision.

Quite often, this approach results in allocative inefficiencies, where the wage bill may take up a huge chunk of available resources at the expense of drugs and equipment. It therefore is not a wonder that most public facilities have a system where staff salaries are publicly funded and services paid in part or in full by patients as 'out of pocket' expenses. Consequently, the poorer section of the population is more disadvantaged. Compared to the middle-class population, the low-class bracket spends a greater percentage of their disposable income on health care, despite the inability to pay.

Output based aid or demand side financing has potential to provide solutions for some of these shortcomings. Firstly it leads to better Targeting. OBA through the use of vouchers and coupons is able to target and reach this population with subsidised health care. Further, use of vouchers and coupons can also be used to target certain services that would otherwise be inaccessible for given population sections. Secondly empowers. An OBA system allows the patient to choose the service provider of his/her choice. Participating service providers (usually a mixture of public, private and NGO facilities) are made accessible to the voucher holder who therefore is at liberty to chose which facility to visit based on his/her perception of quality of service. He/she is no longer limited by the differential cost of services charged by the different categories of providers.

The third benefit is improved efficiency and effectiveness: Reimbursements are paid against specific services provided.



The principle behind this project is that financing inputs e.g. facilities and equipment; do not necessarily result in improved health outcomes. Therefore the OBA concept finances agreed - on outputs with pre-defined quality rather than pre-defined inputs. There are no time-consuming proposals to write and the number of vouchers sold provides an instant measure of success. OBA empowers the consumer: the pregnant woman can choose the doctor or midwife crew she thinks will give her the best service. OBA also empowers the provider: the hospital or private clinic sets its own priorities for spending money. Wastage is likely to be less than in input-based, top down programs.

## Output Based Aid: How it Works

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Consequently, wastage is minimised and there is real incentive to re-invest reimbursements into direct healthcare service providing inputs. Ideally, each facility should make the decision on the priority areas of investments from funds received to further improve quality. The fourth benefit has to do with Quality Improvement. Only accredited facilities can participate in the network of service providers within the OBA system. Accreditation is pegged to fulfilment of defined standards. Remaining within the network is not automatic but is dependant on keeping and improving the required standards. This is further reinforced by the fact that patients have the power to 'vote with their feet' and go to the facilities perceived to have quality services. This is an inbuilt mechanism to ensure that quality standards are maintained.

There are therefore many advantages of introducing OBA interventions either as a 'stand alone' approach or as a complement to an already existing supply-side mechanism. Care should however be taken to ensure that the services provided are well defined. Experience has shown that OBA works well when a fixed value can be assigned to the service package offered.

The service providers therefore receive a previously agreed upon amount for each voucher client they attend to. It is also important to ensure that a proper targeting mechanism exists to ensure that only the target population access the services. In the case of targeting low income groups, for instance, one way of doing this would be to develop a poverty grading tool that is adaptable to poverty dynamics of given settings. Such a tool would make it possible to pick out the most deserving members of the community that require subsidised health care, while locking out those who are able to afford the cost of health care.

*Cynthia Macharia is a Programme Officer, KfW Office, Nairobi*



## Saving Women's Lives - Pumwani Experience

By Godfrey Kariithi

**"...my husband** has no regular work...I don't know what I could have done. I think I could have given birth at home" Says Ruth Wangari, a 22 year old mother from Mathare. Ruth is one among many women in the slums who can not afford good health care. She was fortunate that her medical bill was paid in full; thanks to the RH-OBA project.

In September 2006, the government through the National Coordinating Agency for Population and Development and PricewaterhouseCoopers approached Pumwani Maternity Hospital, Nairobi to implement the RH-OBA Project.

The hospital was to serve the project beneficiaries Viwandani and Korogocho Slums of Nairobi.

"Once the beneficiaries are identified, they are issued with vouchers which they present to the hospital for services. The patient then is served and released unconditionally," say Sylvester Wanjirah, the hospital secretary. The hospital then processes the invoice and submits it to PwC for reimbursement. Pumwani admits

about 200 women per month under this scheme. Over 3,000 women have benefited since the project started in 2006.

This project has increased the hospital's income making it possible to improve its services. In fact, as Dr Charles Wanyonyi, the hospital superintendent, puts it, the challenge is to sustain the set standard. However, this is not without challenges. Mr Wanjirah noted that over 90 percent of the hospital clients is from informal settlements - mostly from Kibera, Kayole, Mathare, Kia-Mbiu yet the project covers only two slums - Viwandani and Korogocho. Although some of the poorest residents of the city come from these slums, the hospital is obliged to waive medical costs to many other patients who cannot afford lest the Hospital is seen to be discriminating among its patients. Due to this the hospital is reportedly losing income.

But Ruth Wangari, the OBA beneficiary, and doctors at Pumwani - the largest public maternity hospital in the city agree; more slums need to be covered by the project and public education should be intensified to ensure that the process is clearly understood.

*Kariithi is a Lecturer at KIMC*

# RH – OBA Project: Model strategy aims to subsidize reproductive health services to the poor

By George Kichamu, Francis Kundu, Josiah Mwangi

## Background:

The Reproductive Health – Output Based Approach (RH-OBA) Project is a joint venture between the Government of Kenya (GoK) and the Federal Republic of Germany. An agreement to undertake the project at a total cost of Euros 6.579 million was signed between the two parties on 7th March 2005.

Funds to finance the project are largely provided by the Federal Republic of Germany through its development bank - KfW Bankengruppe. GoK is also providing some funds to the Project. The objective of this 3 years pilot venture is to improve access to quality reproductive health and family planning services through a voucher system for the economically disadvantaged people living in Kisumu, Kitui, and Kiambu districts as well as Viwandani and Korogocho slums in Nairobi. In addition, the project covers the cost of providing gender based violence recovery services to the same target group.

## Basic Principles of the OBA Concept:

Past experiences with development aid have shown that financing inputs e.g. facilities and equipment does not necessarily result in improved health outcomes. Therefore, as a change of paradigm, the RH-OBA concept seeks to finance agreed on outputs of a pre-defined quality through a voucher system where service providers are refunded for the services rendered under this arrangement.

## How the voucher system works:

There are two types of vouchers namely; Safe Motherhood, Family Planning, and Gender Based Violence vouchers. These vouchers are distributed by NGOs, CBOs, FBOs, and individuals in the five project sites. Before engaging in voucher distribution, each of the distributors



were trained on the use of a poverty identification tool that is used to identify those who are eligible to benefit from the subsidized reproductive health services.

A client who is eligible to benefit from the project services is required to purchase

a voucher for the desired service at a subsidized cost. The client then presents the voucher to an accredited service provider in the project site in exchange for the desired service. At the end of each month, the accredited service providers submit their claims for

the services rendered. These claims are submitted to the Voucher Management Agency i.e. PricewaterhouseCoopers for processing and payment. The Safe Motherhood voucher costs Kshs 200/= while the Family Planning voucher costs Kshs 100/=. As for the gender violence recovery services voucher, it is provided free of charge to those who need these services. Government, private, NGO, and FBO service providers are eligible to participate in this project if they meet the required standard for providing the targeted services.

### Project Implementation:

The Ministry of Planning and National Development through the National Coordinating Agency for Population and Development (NCAPD) is overseeing the overall implementation of this project. An Advisory Board and a Steering Committee have been put in place to assist NCAPD in overseeing the implementation.

PricewaterhouseCoopers and Population Council have been jointly contracted as the Voucher Management Agency (VMA) for the project. This consortium is undertaking the actual implementation. The National Hospital Insurance Fund (NHIF) has been contracted by PwC to providing accreditation and quality assurance services. Due to the complex nature of this project, a backstopping consultant i.e. IGES has been engaged to address any unforeseen issues that may emerge during implementation.

### Project Outputs and Outcomes:

The lessons that will be learnt from this project are expected to contribute further to the formulation and implementation of the National Social Health Insurance Fund that is being considered by the Government. In addition, the project is expected to help in reducing the maternal and infant mortality rates in the five sites of operation. It is also envisaged that health facilities in the project sites will improve on the quality of their services as a result of the incentives that are being offered by this project.

### Project Status

The RH-OBA Project began serving the public in June 2006 after the official

launch that took place at Kombewa Chief's Camp in Kisumu district on 7th June 2006. Kisumu district was the first project site to be activated at the said launch followed by Korogocho and Viwandani slums in September 2006. Kitui and Kiambu districts were activated in November and December 2006 respectively.

So far, safe motherhood services have proved to be the most widely used by the voucher clients. Family planning and the gender based violence recovery services are have not picked up well. Here below are details on the project status.

#### 1. Voucher Service Providers:

The total number of health facilities accredited to the project now stands at 54. Of these facilities, 18 are in Kisumu, 12 in Nairobi, 17 in Kiambu while seven are in Kitui district. Thirty seven percent of the facilities are Government owned while 33 percent are privately owned.

#### 2. Voucher Distribution:

Between June 2006 and January 2008, over 73,000 vouchers have been distributed in the 5 project sites. Safe motherhood vouchers made up for more than two-thirds of the vouchers sold. The chart below shows the voucher sales for

each site;

From the voucher sales table it is evident that Kisumu is leading in the SMH voucher sales (18,669) while Kiambu is leading in the FP voucher sales (12,691). The total voucher sales in Kitui district is less than 10,000 while that of Nairobi is about 13,700.

### 3. Service Provision:

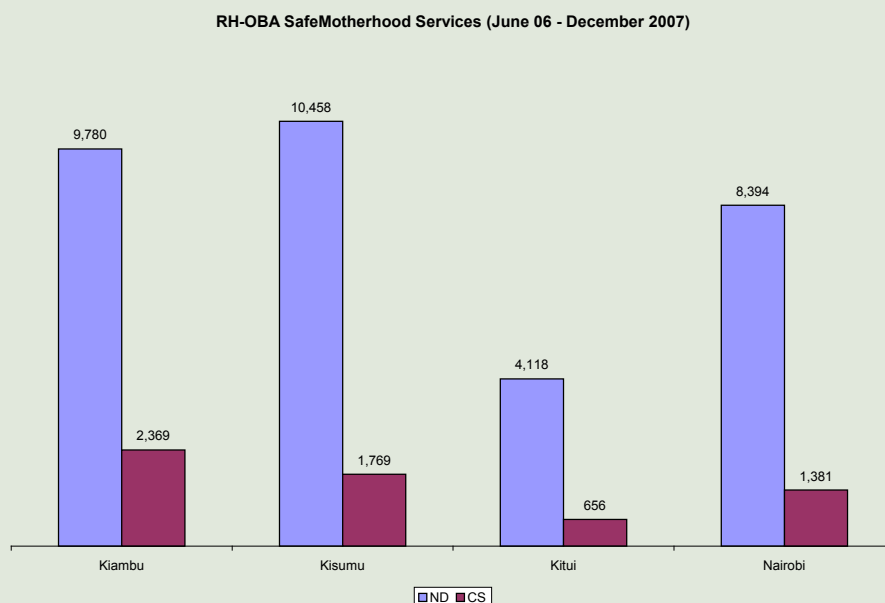
#### a) Safe Motherhood

By the end of December 2007, about 38,900 women had delivered babies in the accredited facilities using the safe motherhood vouchers. Most of these women had normal deliveries (84%) while the rest delivered through Caesarean Section (16%). The chart below shows the distribution of the deliveries;

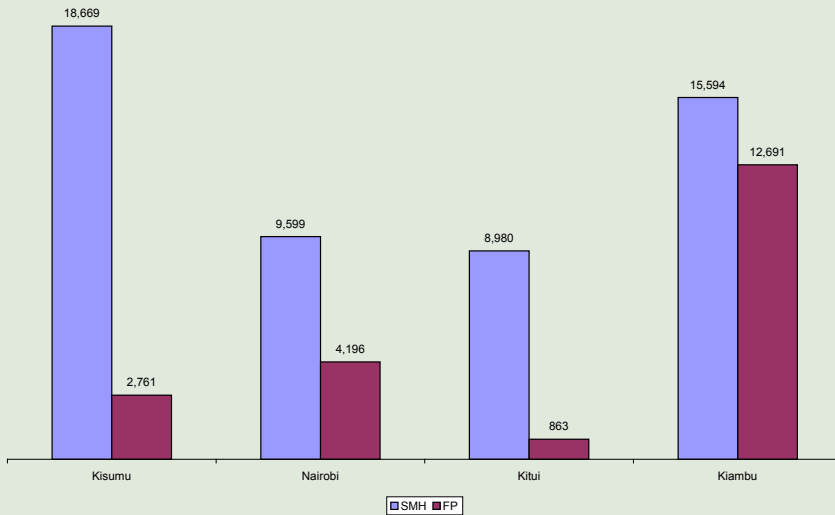
The chart on safe motherhood shows that Kisumu and Kiambu have registered the highest number of voucher deliveries (over 12,000 deliveries each) while Kitui had the least number of deliveries at about 4,700. The Caesarean Section rate was highest in Kiambu (19.4%) and lowest in Kitui (13.7%). Overall, the CS rate was 15.8% of all the voucher deliveries.

#### b) Family Planning

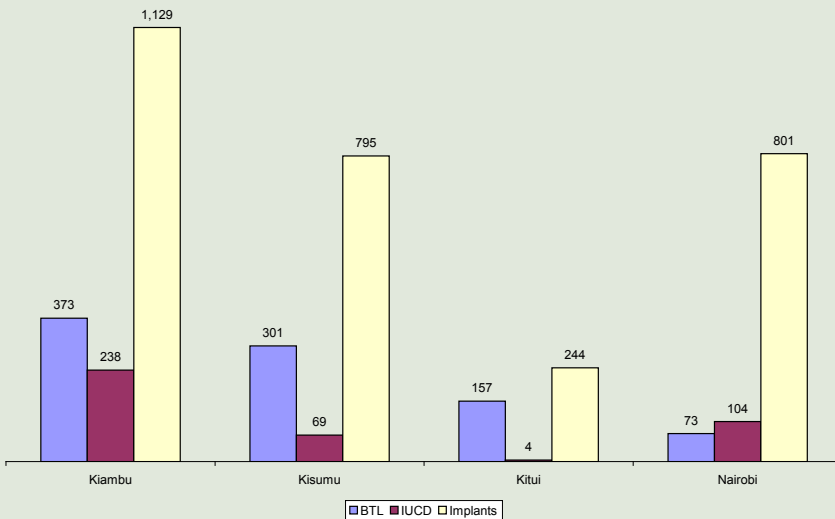
The uptake of the long term family planning services has been below



RH-OBA Project: Voucher Sales (June 2006 - January 2008)



RH-OBA FP Services (June 2006 - December 2007)



expectation. Between June 2006 and December 2007 only about 4,300 clients had accessed these services using the vouchers. The chart below gives a breakdown of the uptake of the long term FP services;

The FP chart indicates that Kiambu had the highest proportion of the voucher FP clients (40.5%) while Kitui had the lowest (9.5%). Implants was the most preferred method among the voucher clients (69%) followed by BTL (21%) and IUCD (10%). Since the project

commenced only once case of vasectomy has been registered.

**c) Gender Based Violence Recovery**

The provision of GBVR services under the RH-OBA project has not done well with only 271 clients being served over a period of 15 months up to December 2007. Nairobi and Kitui recorded the highest number of clients at 222 and 36 respectively. The remaining 13 clients received services in Kisumu and Kiambu. More education and sensitization efforts are being put in place to scale up the utilization of these services in all the sites.

**4. Reimbursements**

The 54 voucher service providers had been reimbursed a total of Kshs 317.5 million for the services rendered to the voucher clients. The breakdown of this amount by type of services is shown in the table below;

From the table above it is evident that over 96% of the reimbursements went towards meeting the cost of providing SMH services while the remaining 4% went towards FP and GBVR services.

**5. Challenges**

Some of the challenges being faced by the project are listed below:

- Low uptake of long term FP methods & GBVR services
- Tracking fraud
- Improving access to services in the remote areas

**6. Lessons Learnt**

Some of the lessons learnt from the one year of project implementation are:

- Cost is a key barrier that prevents the poor from accessing RH services
- Vouchers dignify the poor by providing them with better choices
- Competition between service providers has enhanced the quality of services
- Fraud/abuse needs close and continuous supervision to keep it under control
- Efficiency in claims processing maintains the confidence of providers

**7. Way Forward**

The way forwards for the Project is to:

- Publish scientific papers on the project
- Draw up a plan to phase the project into Ministry of Health for continuation

*(For additional information on the RH-OBA Project contact Francis Kundu email: fkundu@ncapd-ke.org)*

# Ensuring Success and Accountability



*Working in the background to ensure that the vouchers are distributed, the bills are paid and the RH targets the right people – OBA Project is a strong team at PWC*

**Everyday, voucher** distributors in the RH – OBA Project distributors and staff work hard to ensure that the people who receive vouchers are the most needy.

“At each project site, a Poverty Identification Tool has been developed that is used to check on the poverty status of the prospective voucher client,” notes Ms. Mwikali Mwangi, the Field Manager for the project in Kisumu. “The tool is specific for each region checking on their lifestyle to determine economic potential of the client.”

The verification of the client does not end here. RH-OBA field staff conduct home and hospital visits to cross check whether the client told the truth. During hospital visits, some of the things checked on are

the kind of people who visit the mother and the accessories she has for the new born. If a client is proven not to deserve, the funding can be withdrawn at this stage too. The home visits are more common in urban areas and are done before the client is given the vouchers.

All districts have their own uniqueness with areas with high populations proving harder to manage while it is more difficult to distribute vouchers in areas where population is sparse. To meet these challenges, the distribution methods are constantly reviewed. For example, Kiambu has the highest number of target and non-target populations living at close proximity. It was thus necessary to first identify the poverty pockets in the district, for where project beneficiaries could be identified. The RH-OBA Project

team was able to determine the 39 poverty pockets in the district and also the poverty-mapping tool to ensure only the most needy benefited. In Kisumu, key target populations have been reached through specific targeting although the beaches along the lake have proven a bit more difficult to penetrate. However the obvious method of tracking effectiveness in the distribution is a rise in the number of claims from health centres in the specific region.

## Claim processing

“The RH – OBA Project operates on the insurance model whereby a client has to first purchase the voucher before getting services,” says Mr. Boniface Mbutia who oversees claims processing for the Project at PwC adding that this is not the case for GBVS clients, as they do not have to get the voucher beforehand.

Mr. Mbutia notes that the providers have been guided on how to apply for the claims. A provider sends to the Voucher Management Agency an invoice with a duly completed claim form, the original voucher and a medical report or discharge summary as attachments. A claim cannot be processed if one of the supporting documents is missing.

The VMA cannot pay in cases of obvious fraud, which can be identified through an inconsistent medical report, claim forms not duly filled and the provision of services not supported by the project.

“The medical report or discharge summary helps us ascertain the services provided and where in line with the services supported by the project,” Mr. Mbutia adds.

Several issues would make the VMA not process a voucher. For one, the RH – OBA Project insists on full safe motherhood services for a client to be eligible for the voucher. Thus, if it were noted that the client did not attend antenatal clinics, the health facility would not be reimbursed for the costs incurred.

The payments for emergency services are

offered in line with the contracts arrived at with the providers. For example, the project pays Ksh.21, 000 for a caesarean section and cannot pay a cost above this.

When they lodge a claim, service providers are paid within 30 working days. The project encourages them to claim for payment after the client has received all the services. Money is then credited to the health provider's bank account.

The project encourages health care providers to channel money received to areas that will outlive the project. Due to this, many providers have been able to purchase needed equipment with cash they get from the project. For example, Kijabe Mission Hospital has built a new maternity unit, built a newborn facility and purchased an ultra sound machine with project funds. As for Government health facilities, there has been a noted decline in the number of waivers they have to give their clients.

### The FP Voucher Uptake

"The uptake of FP services has been low compared to the other components," Ms. Mwango notes. The key challenge faced by this component is the lack of male involvement in family planning. A case in point is that since the start of the project, only one vasectomy has been done so far. Most mothers also participate in the project without their partners' knowledge.

The FP voucher is a one use only voucher and targets long-term FP methods only. These are BTLs, sterilizations, vasectomy, implants and IUCDs. It does not support short-term methods such as injectables, pills and condoms.

To improve uptake, the Project field staff and CBOs contracted by the project have been conducting outreach services in the target regions. In addition, leading health care provider Marie Stopes has been contracted to support these services due to its long experience in FP and RH service provision.

A need to redesign the GBV component has also been identified so that all facilities can be able to provide GBV services to clients. Currently, most health workers in the regional health centres are not trained to deal with GBV cases.

### Marketing

To increase uptake, the VMA has supported various marketing initiatives. At the initial stages of the project, voucher distributors and project staff were given t-shirts to use during field visits. In addition, fliers and posters were developed for distribution at the project site. Initially radio was also used in Kiambu and Kisumu to publicise the Project.

Public barazas have been the key contact point for the project and the community. Through the facilitation of the provincial administration, RH – OBA field staff and

voucher distributors have been able to brief barazas on the project and how the community can benefit. Project staff also conducts outreach services in churches and dispensaries where mothers going for ANC visits are briefed on the project. Branded booths located at chief's offices have also proved to be a good marketing point for the vouchers.

However, word of mouth has proved to be the best marketing tool. Most of the new voucher clients have said that they were informed on the project from mothers in their neighbourhood who benefited from it.

**Kadi Ya Uzaaji**  
huduma za uzaaji kwa bei nafuu na usalama

**KADI ZA UZAAJI** | Zinauzwa karibu nawe kwa bei nafuu na unaweza kuzitumia kwenye kliniki na hospitali zilizo idhinishwa kulipia huduma za uzaaji kwa njia salama.

# Nairobi Women's Hospital offers hope for GBV victims

By Kenpop Team



*GVRC Staff attend to Internally Displaced Persons*

**Over the past** few years, the Gender Violence Recovery Centre (GVRC) at the Nairobi Women's Hospital has positioned itself as the leading provider of services to sexual assault survivors in Kenya. Launched as a nonprofit charitable trust by the Nairobi Women's Hospital in March 2001, the GVRC has treated thousands of survivors of rape and domestic violence. On average 10 to 15 clients are seen at GVRC everyday. The GVRC is backed by a hospital with the capacity to offer professional medical services for sexual violence survivors

The GVRC provides free services to sexual assault survivors including HIV Post Exposure Prophylaxis (PEP) drugs, professional counseling, monthly support group sessions for survivors, and cooperates with the Ministry of Health referral system through Kenyatta National Hospital for further care, legal aid services, a free hotline on gender-based violence, training and capacity building of service providers in other facilities and dissemination of information on gender violence to the public. GVRC links with other agencies to train health workers,

police and other service providers on skills of proper handling of GBV survivors.

It costs between Kshs 4,000 to Kshs 600,000 to treat a GBV survivor depending on the magnitude of their problem. These costs are out of reach for the poor who are the majority.

The Nairobi Women's Hospital has been contracted to provide gender based violence recovery services (GBVRS) to the poor living in the project sites. In addition, the Nairobi Women's Hospital has been contracted to build the capacity of medical personnel in other districts so that GBVRS services can be provided within reach in those regions.

## Results

Between September 2006 and December 2007 GVRC treated 3,442 GBV cases, of which 2,960 (86%) were sexual assault cases while 482 (14%) were victims of domestic violence. Of the 2,960 sexual assault cases treated 209 were from areas supported by the OBA project. Out of the 483 domestic violence cases, 13 cases came from OBA areas and were treated at the hospital bringing the total number of RH-OBA Project clients to 222.

However these figures were recorded before the onset of the political crisis in Kenya, which has led to a large number of clients seeking post rape care. Indeed the entire Nairobi Women's Hospital is at the forefront in response to the emergency after the skirmishes that followed last year's general election.

## Lessons & Recommendations

Some vital lessons have been learnt while implementing gender based violence recovery service under OBA. The need for more public education is chief among these. The other is to redefine the service to consider the unique circumstances which cause the need for GBVRS. This is because it is socially inappropriate to "anticipate" rape by buying a voucher before the act. It should also help if rape is regarded as an emergency for treatment regardless of economic status of victims. The recent crisis in country has made vividly clear to providers such as GVRC.

The recommendation of the center is that when it is absolutely necessary that assessment to determine capacity to pay should be carried out then this should be done at facility rather than community level as the patient is receiving care.

# OBA RH Project Benefits from NHIF Experience

By Joseph Githinji

**In 1966**, the Government of Kenya established the National Health Insurance Fund (NHIF) as a state corporation to provide medical insurance cover to registered members and their declared dependants (spouse and children). Membership is open to all Kenyans who have attained the age of 18 years and have a monthly income of more than KSh. 1,000.

The NHIF operates throughout the country and works with accredited hospitals to provide healthcare services. Accredited organizations are those recognized by the NHIF and allowed to offer services to Fund members and claim reimbursements thereafter. Accreditation criteria aims to encourage hospitals to improve on service quality

Due to its placement and experience in health care, NHIF was sub-contracted by the Output Based Aid-Reproductive Health (OBA RH) Project to offer accreditation and quality assurance services for the project. A health provider is accredited on the basis of how accessible the facility is to the target population, services offered, available human resources, infrastructure and equipment. The NHIF contracted health facilities for the project are referred to as Voucher Service Providers (VSPs). The NHIF plays a crucial role ensuring implementation conforms to set quality standards at all project sites. So far 54 VSPs have been contracted; 18 in Kisumu, 17 in Kiambu, 7 in Kitui and 12 in Nairobi.

## Achievements

Since initiation of the Project, there have been noted achievements at the selected VSPs which include; enhanced quality of care at VSP sites due to increase in financial base as evidenced by strengthened existing structures; staff employment, equipment and other amenities, accessibility to services, defined benefits therefore easy to act

as opposed to the rebate system and exposure of NHIF accreditation system and quality assurance systems to peer review.

The Project has faced a number of challenges among them being staff migration which hampers continuity of quality improvement plans and activities initiated at the accredited facilities. In

addition, some facilities are located within areas that are hard to access, which makes it difficult to monitor progress. There is notable increase in workload for the staff in the project while in some instances staff attitude has negatively affected service delivery.

Githinji works for NHIF

## Nyambu Albert, A Changed Man

Twenty-two-year-old Nyambu Albert is a serviceman with the National Youth Service (NYS), a paramilitary institution that provides young people with vocational training in exchange for completing basic training and community work. This year, Men as Partners (MAP) joined forces with NYS to conduct five-day workshops for servicemen and servicewomen throughout Kenya.

### A Changed Man

I confess to have been a gender-insensitive person. Where sex was concerned, I believed a young man should experiment with many girls before he decided which one to marry. I wondered how one's girlfriend could claim to be raped by her boyfriend. I never thought my girlfriend had any sexual rights, and we never discussed sex, since I assumed that she should comply with my demands. I have had many unhealthy relationships because I have been brought up in an environment where women are considered inferior to men and are not involved in decision-making.

The MAP training made a great impact in my life. In the past, I attended HIV awareness training, but no one gave me a chance to air my views and demystify myths about HIV. MAP's training method involved us fully. It gave me a chance to put a stop notice on my life. I had heard so many myths about abstinence and never appreciated that HIV/AIDS is real. Now I know why it is important to know one's status. HIV could ruin my future. It is not [just] a disease for prostitutes, and even my girlfriends could be infected. I used to think young people could not do without sex. I thought sexuality was only about sexual intercourse. I have now made a personal commitment to stick to one partner, and I proposed to my girlfriend that we visit the nearest voluntary counseling and testing site to know our current status.

I am now a completely changed person. I plan to organize youth groups back home, especially those in my football clubs, to educate them about HIV. Nyambu Albert, Participant.

SOURCE: Engender Health



Friends of Youth conducting SRH training

## Innovations of Family Health Options Kenya Youth Health Project in Nyeri

By Fidelis Ndung'u

**The Nyeri Youth Health Project (NYHP)** is a locally designed, culturally consistent Sexual and Reproductive Health (SRH) programme for young people. The programme employs respected parents to give young people SRH information to promote an improved environment that is responsive to their SRH information and service needs. The NYIP has trained a network of collaborating service providers, mostly from the private sector, on SRH and youth friendly services. In addition, youth in need of services are given a coupon that entitles them to subsidized SRH services at participating service provider facilities.

NYHP is a truly 'homegrown' intervention. It is consistent with Kikuyu traditions where parents assigned trusted young parents – 'atiri' - to give guidance on sexual-related issues. In the NYHP, respected trusted young parents in the community are trained on adolescent reproductive health issues and advocacy. These parent motivators, referred to as "Friends of Youth" (FOYs), work in their communities to educate both adolescents and parents on RH, and to encourage dialogue between them. FOYs use a curriculum known as "Life Planning Skills for Young People in Kenya" which includes sessions on community, family and individual values, adolescent development, sexuality, gender roles, relationships, pregnancy,

STIs, HIV and AIDS, harmful traditional practices, substance abuse, planning for the future, children's rights, and advocacy.

FOYs conduct outreach activities with existing youth groups, such as church groups or school groups, or form their own youth groups. They meet young people in groups and as individuals. FOYs also work with adults in the community to improve attitudes and the atmosphere surrounding how adolescent issues are addressed at the community level. FOYs also work closely with schools in the project area by training teachers on communicating with young people. There are 25 FOYs (18 women and 7 men). Each FOY is assigned a specific geographical area, covering approximately 300 adolescents. While they are responsible for outreach in their areas, FOYs often work together in pairs or small groups to complement each other's skills.

In addition to the FOYs, Family Health Options in Kenya (FHOK) trained a network of local doctors, clinical officers, and chemists mostly from the private sector – who provide youth-friendly sexual and reproductive health services. FOYs refer youth to service providers with a coupon, which entitles them to services at subsidized cost.

*Fidelis is the Central Regional Population Coordinator*

## Kenya Family Planning Program Internationally Recognized as "Story of the Year"



**The Implementing Best Practices (IBP) Initiative**, an international initiative dedicated to improving access and quality of reproductive services, has recognized Kenya's family planning revitalization program as the 2006 "Story of the Year". The Kenya IBP team, led by the Division of Reproductive Health of the Ministry of Health, in collaboration with partners, including the U.S. Agency for International Development (USAID) and the ACQUIRE Project strategically implemented supply, demand, and advocacy best practices which resulted in remarkable family planning achievements. Many of these achievements resulted from previous FP programming efforts under the Engender Health led AMKENI Project.

In close partnership with the MOH, the ACQUIRE Project implemented the family planning revitalization initiative in Kisii District, Nyanza Province in western Kenya. Focusing holistically on supply, demand, and advocacy lead to impressive results including a striking increase in underutilized long-acting and permanent methods such as the IUD and female sterilization.

*SOURCE: ACQUIRE Project*

# It Takes Two: Men as Partners in Maternal Health

Kenpop Team



**Having children** is a partnership. It is one in which women face greater risks, both because of physiological differences and gender inequities. Women have a right to health, but protecting that right often depends on a partner's support.

Experience shows that male involvement can make a substantial difference when it comes to preserving the health and lives of women and children. Men, make most of the decisions within the family and in government where they preside over policy and programmes that directly affect women and girls. Quite often though, too many women die from easily preventable complications of pregnancy and childbirth simply because decisions were not made in time. The key message of the celebration to mark World Population Day on July 11, 2007 therefore

was that opportunities must never be wasted and men and women partnerships should be strengthened to ensure women enjoy a life of health, dignity and equal opportunity.

This emphasis on men's involvement in maternal health comes at the midpoint of the 15-year period set for achieving the Millennium Development Goals. It is now clear that the target of reducing maternal deaths by 75 per cent by 2015 will not be met without the concerted efforts of all involved. Men – as partners, fathers, husbands, brothers, policy makers and community and religious leaders – have a critical role to play in safeguarding the maternal health of women.

Thoraya Ahmed Obaid, Executive Director of the United Nations Population Fund (UNFPA), in a statement during the celebration stated that men should

more vigorously participate as partners in maternal health in order to significantly reduce the number of women who die each day in childbirth.

In Kenya the day was celebrated with leaders calling on men to take responsibly in reproductive health matters. The Chairman of the Parliamentary Network on Population Development reiterated the need for men to protect women; which he observed is traditional of all African men by ensuring proper care to women during the vulnerable period of pregnancy. He called on government to include sanitary towels as an essential item in the package for the Free Primary Education. Other members of parliament who graced the occasion passionately called on Kenyans to take all children to school, as this was one way to enlighten them and ensure they enjoyed greater health and opportunity for all.

# The Standard Days Method: A new family planning option

BY Caroline Blair

## The Standard Days

Method® (SDM) is billed as an innovative and cost-effective approach to family planning though not yet well known. It is slowly being introduced in several countries, including Benin, Mali, Senegal, Rwanda and the Democratic Republic of Congo.

The SDM is a fertility awareness-based method that is appropriate for women with regular menstrual cycles between 26 and 32 days long. It identifies 8th. to 19th. as the fertile days of the menstrual cycle. To prevent pregnancy, couples can either use a condom or abstain on the 12-day fertile window.

CycleBeads®, is a visual tool designed to help couples use the method. The woman or couple use CycleBeads to track the menstrual cycle, identify the fertile days and monitor cycle length. Each bead represents a day of the cycle.

The black ring shown here on the red bead is moved one bead each day. When the bead is on the brown part, the woman is unlikely to get pregnant; when it is on any of the white beads, she has a high probability of pregnancy.

## Scaling up SDM

With support from USAID, Georgetown University's Institute for Reproductive Health has developed the SDM method, which has been successfully introduced in a number of countries around the world. Evidence from a number of studies has shown that the SDM with CycleBeads is a potentially important addition to the family planning method mix that can be offered at the clinical and community level and is also culturally appropriate besides encouraging couple communication about family planning.

SDM is increasingly being accepted. In Benin, for example, the SDM was

introduced through a pilot study at the request of the Ministry of Health. The study determined that strong demand for the method existed, the SDM could be offered effectively to the community through existing service delivery channels, acceptability and continuation of use with the method were high, and the SDM could be used correctly and consistently. Based on these findings, the MOH included the SDM in its reproductive health norms and requested technical assistance to expand the delivery of the method nationwide. To date, the SDM is offered in more than 150 sites and through numerous community-distribution channels and pharmacies in the country. Quoting data provided by the MOH (April 2002–December 2007), the IRH reports that SDM users represent 14 percent of new family planning acceptors in Benin, because the method is perceived as “natural” and has no side effects. Similar studies carried out in Democratic Republic of Congo, concluded that the SDM was generally well received by both providers and users. The MOH in that country included CycleBeads in its five-year contraceptive security plan and in national norms and protocols, the national list of essential medicines, and in the national in-service family planning training curricula. In Rwanda, operations research on the SDM was conducted in partnership with the USAID-supported project implemented by IntraHealth and the Rwandan Ministry of Health. Building from this experience the SDM is now being integrated into family planning services on a larger scale.

*Caroline Blair formally worked for UNFPA Kenya office and is currently the principal consultant for the assessment of this method under the auspices of George Washington University, USA.*



### CycleBeads: An Easy Way to Use the Standard Days Method

If your period does not start by the day after you move the ring to the last BROWN bead, your cycle is longer than 32 days.

The RED bead marks the first day of your menstrual period. On the day your period starts, move the ring to the red bead. Continue to move the ring one bead each day.

The DARK BROWN bead helps you know if your cycle is less than 26 days long. If your period starts before you move the ring to the dark brown bead, your cycle is shorter than 26 days.

All BROWN beads mark the days when you are not likely to get pregnant if you have unprotected sex.

All WHITE beads mark the days when you are likely to get pregnant. Do not have unprotected sex on the white bead days if you do not want to get pregnant.



# Meeting the Sexual and Reproductive Health needs of the Youth

*BY FHOK and Kenpop Team*

**Aspirations of** young people are constrained by many factors: social structures that are not favourable to young people's participation, prolonged economic crises, low levels of education especially for girls, lack of employment opportunities, devastating effects of HIV/AIDS and other pandemics. Young people have dreams too, but the very hostile environment that they face leads them to risky behaviours and violence. Non-governmental organizations in partnership with Government agencies have initiated different programmes to try and ensure that young people can develop economically and lead health lives.

Family Health Options Kenya (FHOK) has been in the field of Sexual and Reproductive Health (SRH) programming for young people in Kenya for quite sometime. FHOK Adolescent/Youth programmes started in 1977 as Family Life Education (FLE) project providing SRH information to young people in schools. The project later expanded to accommodate the out of school youth and service provision through model youth centres. The primary interest of the project is to increase awareness among all adolescents and young people

on their Sexual and Reproductive Health and Rights (SRHR), and to empower them to make informed choices and decisions regarding their sexuality. Currently the programme has expanded from two to five youth centres located in Nairobi, Mombasa, Nakuru, Eldoret and Kisumu towns.

The Youth Centres are managed by the young people themselves who are trained Peer Youth Educators (PYEs) and provides an environment where both girls and boys discuss their issues, share experiences, learn life planning skills, access RH services and reciprocate the same by reaching out to their peers with information through organized Peer Education and Community Outreach activities. By doing so the Centres hope to contribute to the vision of young people living quality healthy lives.

The Youth Programme has built the following strengths in reaching the youth with SRH information and services through; peer approach, wide range of services and flexible operating hours, high degree of confidentiality, strategic location, affordable services, offered with dignity and respect, use of edutainment approach or enter educate through project activities such as drama and dance that are designed to provide fun

to the target group

One of the major lessons learnt while running the Nairobi Youth Counselling Centre is that sexuality is one of the major concerns of the youth in Kenya today. Research shows that most of the Reproductive Health (RH) problems facing adults today have their genesis in their adolescent period. Sexual activity begins early among the youth in Kenya and is high among adolescents. The breakdown in family systems, urbanisation, and the influence of the mass media are some of the major contributing factors to increased sexual activity among adolescents. There is need to increase access to RH information and services for the youth so as to delay their sexual debut, limit the number of sexual partners, and encourage contraceptive use for those who are sexually active.

Lessons learnt in programme implementation indicate that decisions on sexuality among the youth are strongly linked to one self-esteem, aspirations and perception of opportunities. In order to achieve responsible adulthood, adolescents and youth need to develop skills in problem solving and life planning to enhance responsible decision-making, and empowered to make and take control of their decisions, which is the role

FHOK and other Youth Serving Organizations are partnering with the Government through the Ministries of Youth Affairs, Health and National Coordinating Agency for Population and Development to scale up youth centre approach and offer integrated services to the youth.

The intention is to develop appropriate and gender sensitive SRH knowledge and skills among adolescents and the youth. The envisaged Youth Empowerment Centres would provide peer friendly services and an environment where both boys and girls discuss their issues, share experiences, learn life planning skills, access RH services and reciprocate the same by reaching out to their peers through organised Peer Education Community Outreach activities. By doing so, the centres hope to achieve the vision of ensuring young people contribute to the general development of the country. Source: FHOK, Kenpop Team

# Long lasting Mosquito Net Factory Launched in the Region



By Josiah Mwangi

**The opening of** Olyset Net production factory in Arusha that will manufacture long-lasting mosquito nets in the East African presents a major breakthrough, with the region now poised to get better access to what scientists hail as the most effective malaria prevention tool. The Olyset Net factory is a joint venture between Sumitomo Chemical of Japan and A to Z Mills of Tanzania, with the former transferring the production technology without any royalty charges.

The new venture will result in an annual production capacity of 10 million nets. Additionally, sewing, cutting, packaging and distribution satellites will be created in several African countries including Kenya.

The reduction in number of people seeking treatment for malaria in Africa has largely been attributed to the increase in use of treated bed-nets, with many countries recording lower malaria incidences in recent years.

Following WHO-driven research in several countries, it has been established that use of treated nets reduces malaria cases by up to forty percent, but it is only recently that governments undertook serious campaigns to make the nets available to the general populations.

The result has been lower incidence of the disease among the prone populations, mainly among pregnant women and children below the age of five

years.

Health authorities have therefore committed to making the treated nets available to as large a population as possible, in a bid to manage a disease that kills up to 90 African children every day, and takes up close to one third of many African countries' health budget. However, one drawback has been the failure by many families to re-treat their nets after the recommended every six months, thereby rendering them less efficacious.

In response, researchers developed a method of manufacturing nets that would make it unnecessary to re-treat the nets. Now known as the long lasting insecticidal bed-nets (LLIN), the use of these nets is widely seen as a breakthrough that will finally help Africa manage its most devastating affliction.

The impact has been so encouraging that the World Health Organization now recommends that governments should distribute the nets to entire populations, rather than focus on those at most risk. For instance, in Kenya, from 2004 to 2006, a near ten-fold increase in the number of young children sleeping under insecticide-treated mosquito nets was observed in targeted districts, resulting in 44% fewer deaths than among children not protected by nets.

The data from Kenya was the first demonstration of the impact of large-scale distribution of insecticide treated mosquito nets under programme

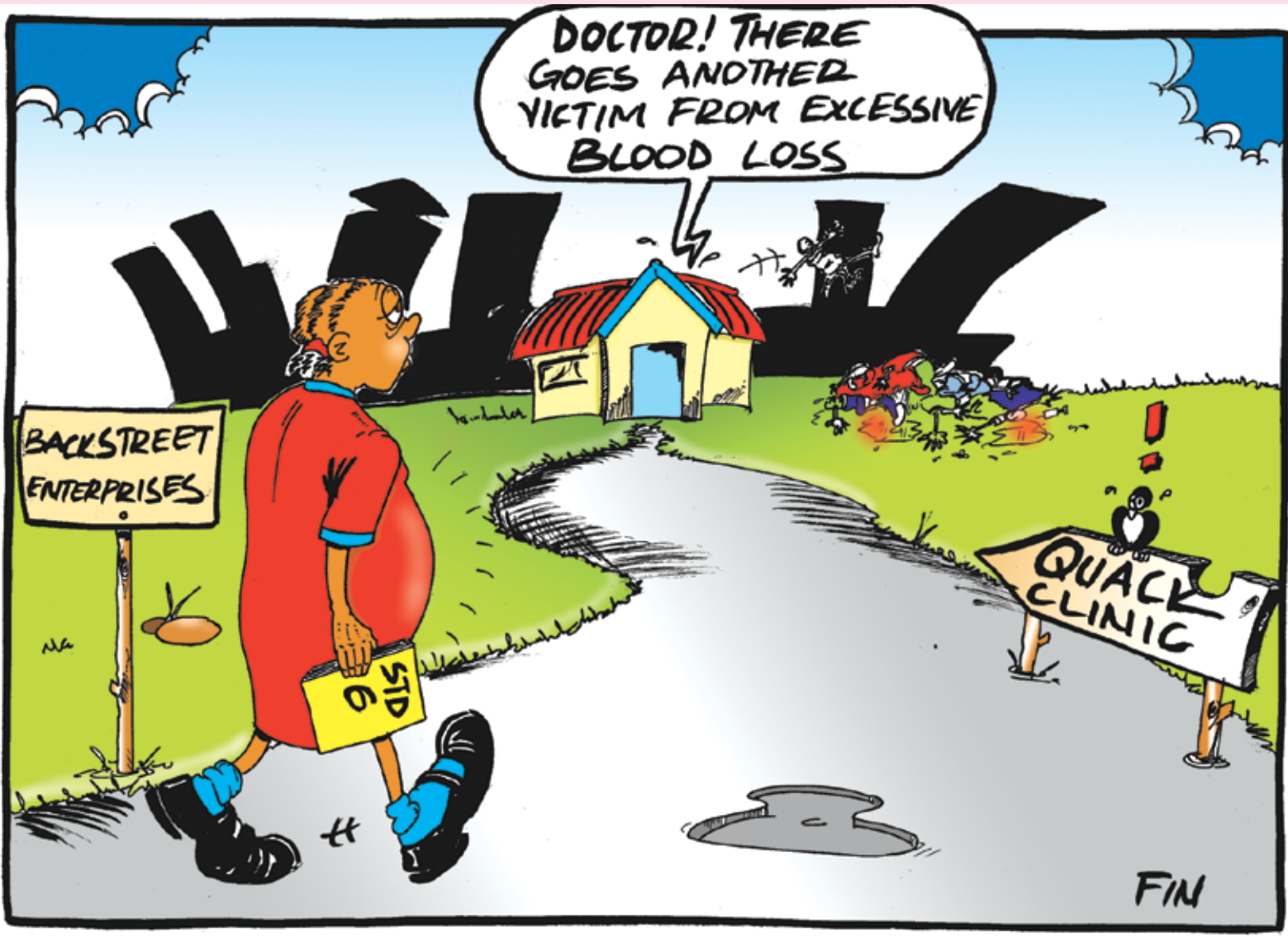
conditions, rather than in research settings, where, in different parts of Africa, reduction observed in overall mortality has ranged from 14 % up to 60 %.

While current rates of coverage are generally low, the availability and use of nets have increased appreciably over the past 10 years, particularly in countries where nets were not normally used. Global health authorities have been pushing and facilitating technology transfer and stimulating local production of LLINs in Africa, in efforts to make the nets accessible for those in need.

Current data indicates that most African households in malaria risk areas do not possess any net, whether treated with insecticide or not. To cover all people at risk, it is estimated that about 260 million nets would be needed in Africa.

In most malaria-endemic African countries the public sector does not have the financial or logistic capacity to extend net use to the scale required. In order to expand ITN use in Africa, it is generally agreed that efforts at increasing synergy between public and private sector activities are needed.

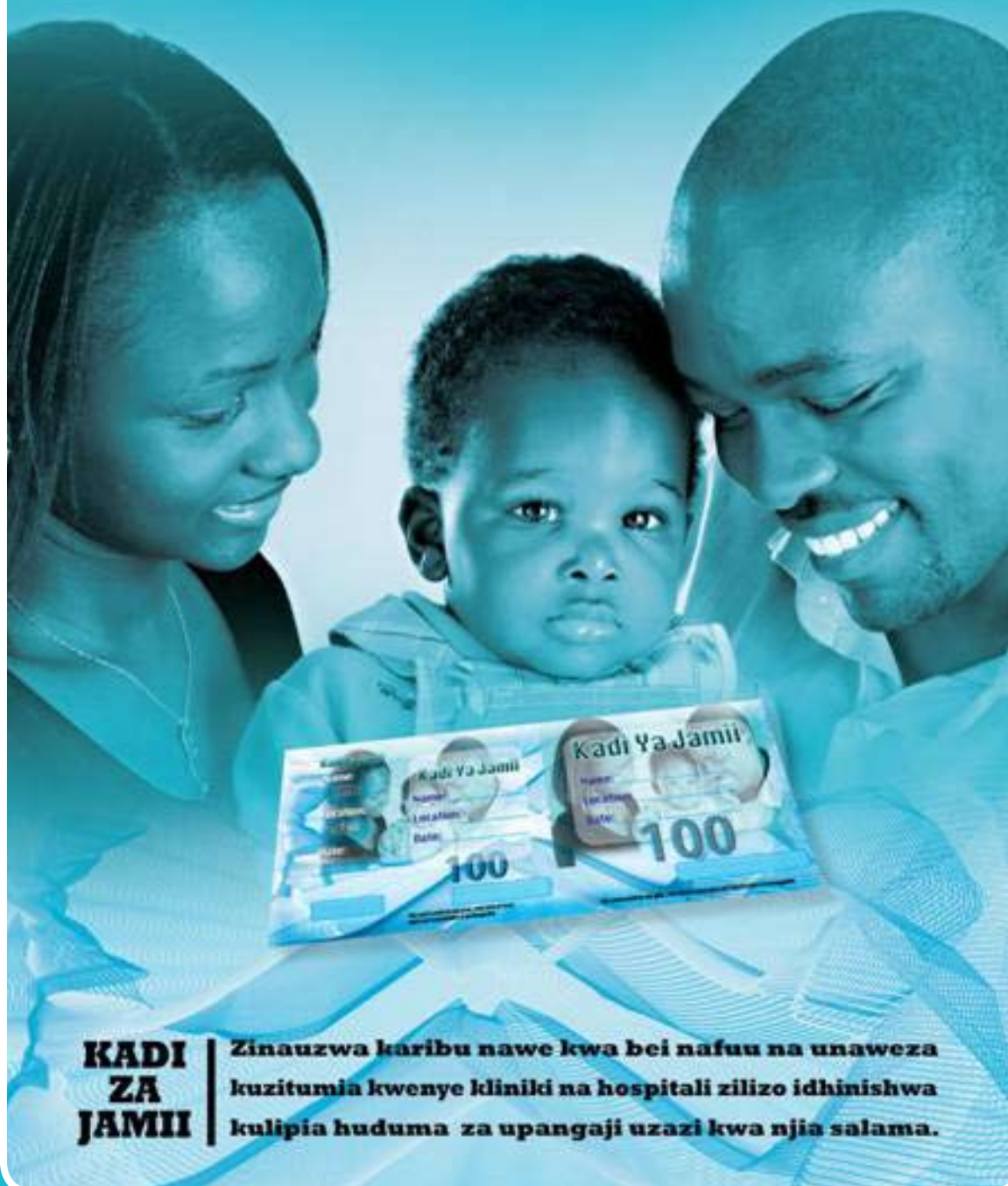
The opening of the Olyset Net production factory in Arusha presents a major milestone towards stimulating local production and eventually ensuring faster and affordable access to LLINs, especially in East Africa. Current demand for the nets outstrips their supply by a large margin.



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# Kadi Ya Jamii

huduma za upangaji uzazi kwa bei nafuu na usalama



**KADI  
ZA  
JAMII**

Zinauzwa karibu nawe kwa bei nafuu na unaweza kuzitumia kwenye kliniki na hospitali zilizo idhinishwa kulipia huduma za upangaji uzazi kwa njia salama.

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