Technical Working Paper

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MLE Measurement, Learning & Evaluation Project for the Urban Reproductive Health Initiative

Measurement, Learning & Evaluation of the Kenya Urban Reproductive Health Initiative (Tupange):

Kenya Endline Service Delivery Point Survey 2014

July 2015

This report presents the findings from an analysis of the endline survey results from samples of facilities, providers and exit interview clients in five cities in Kenya. The report was written by the Measurement, Learning & Evaluation (MLE) Project of the Urban Reproductive Health Initiative and the Kenya Medical Research Institute – Research, Care and Training Program (KEMRI-RCTP). The MLE Project was implemented by the Carolina Population Center at The University of North Carolina at Chapel Hill (UNC-CH) in partnership with IntraHealth International. The Tupange program was implemented in Kenya by a consortium led by Jhpiego.

The opinions expressed in this report are those of the authors and do not necessarily reflect the views of the donor organization, the Bill & Melinda Gates Foundation. Additional information about this report may be obtained from:

Ilene Speizer
Carolina Population Center
206 West Franklin St.
Chapel Hill, North Carolina 27516
Tel: +1 (919) 962 - 3513
Email: speizer@email.unc.edu

Information about the Urban Reproductive Health Initiative and the MLE project may be obtained at *www.urbanreproductivehealth.org*.

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Cover photograph:
A young mother receives family planning counseling at a local government facility in Nairobi, Kenya.

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We are delighted to present the endline Service Delivery Point Survey Report for Kenya, whose initial drafts were designed and written by the Kenya Medical Research Institute with technical support from MLE. The MLE project constituents—the Carolina Population Center at the University of North Carolina at Chapel Hill (CPC-UNC) and IntraHealth International—in collaboration with and with inputs from the Kenya Urban Reproductive Health Initiative (Tupange) worked to finalize this report in its current form.

The endline service delivery point survey was executed in the five target cities and urban centers (Nairobi, Mombasa, Kisumu, Kakamega and Machakos) by the Research Care and Training Program (RCTP) of the Kenya Medical Research Institute (KEMRI) with oversight from MLE. We would like to acknowledge the contributions of the RCTP-KEMRI staff at various levels, in particular Dr. Maricianah Onono, Co-principal investigator and Overall survey Technical Lead; Dr. Serah Gitome, Co-investigator, Mr. Kevin Kamolloh, National Survey Coordinator, Mr. Elijah Asadhi, Monitoring and Evaluation lead, and Mr. Ferdinand Motari, Data Manager.

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It is our sincere hope that this report will document Tupange's efforts and successes in meeting its goal to increase the modern contraceptive prevalence rate in the intervention cities. Further, we hope this report provides evidence for future family planning programs in Kenya and elsewhere.

Dr. Elizabeth Bukusi, MBChB, M.Med (ObGyn), MPH, PhD, PGD
(Research Ethics)
Kenya Medical Research Institute (KEMRI)

Measurement Learning, & Evaluation
Ilene S. Speizer

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List of Abbreviations

ART	Antiretroviral Therapy
BMGF	Bill & Melinda Gates Foundation
CCP	Center for Communication Programs
CHEW	Community Health Extension Worker
CHV	Community Health Volunteer
CPC-UNC	Carolina Population Center/University of North Carolina
CPR	Contraceptive Prevalence Rate
FBO	Faith-Based Organization
FP	Family Planning
GPS	Geographic Positioning System
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
ICRW	International Centre for Research on Women
IEC	Information, Education and Communication
IMR	Infant Mortality Rate
IUD	IntraUterine Device
KDHS	Kenya Demographic Health Surveys
KEMRI	Kenya Medical Research Institute
KES	Kenya Shilling
KNBS	Kenya National Bureau of Statistics
LAPM	Long-Acting and Permanent Methods
M&E	Monitoring and Evaluation
MCH/MNCH	Maternal Newborn Child Health
MDGs	Millennium Development Goals
MLE	Measurement, Learning & Evaluation
MMR	Maternal Mortality Rate
MOH	Ministry of Health
MSI	Marie Stopes International
NCPD	National Coordinating Agency for Population and Development
NGO	Nongovernmental Organization
NMR	Neonatal Mortality Rate
NRHP	National Reproductive Health Policy
OOP	out of pocket
PAAL	Pharm Access Africa Limited
PMTCT	Prevention of Mother to Child Transmission
QA	Quality Assurance
RCTP	Research Care and Training Program
RH	Reproductive hHealth
SDM	Standard Days Method
SDG	Sustainable Development Goals
SDP	Service Delivery Point
SSA	sub-Saharan Africa
STI	Sexually Transmitted Infection
TB	Tuberculosis
TFR	Total Fertility Rate
TOTs	Trainer of Trainers
UNC-CH	University of North Carolina at Chapel Hill
URHI	Urban Reproductive Health Initiative
WFS	World Fertility Survey

Executive Summary

Background

This report summarizes the findings of a service delivery point survey undertaken between October and November 2014 as part of the impact evaluation of the Kenya Urban Reproductive Health Initiative (Tupange). The survey, designed by Measurement, Learning & Evaluation (MLE) of the Urban Reproductive Health Initiative project, covered a wide range of health facilities in urban centers of Nairobi, Mombasa, Kisumu, Machakos and Kakamega.

Overview of Survey

A total of 377 facilities were audited in the endline survey; of these facilities, 110 were public while and 267 were private facilities. Out of the 377 facilities visited, a total of 966 providers were interviewed. More health health-care providers were interviewed in private facilities (575 providers) than in public facilities (391 providers). Across all cities, at both baseline and endline, a total of 4,861 exit interview clients were interviewed; the interviewed respondents were primarily seeking either FP services or curative services.

Regardless of facility type and city, by endline over 60 percent of the health facilities reported that they offered FP services, antenatal care, HIV care, and STI services.

Integration of FP Services into MCH Services

A key objective of the URHI was to integrate FP into other health services with a focus on MCH services. The percentage of women who received FP information during postabortion and postnatal services increased since baseline, whereas integration of FP information into antenatal care, delivery services, child care, and curative services decreased since baseline. Among women who were not using FP and did not receive a FP method, referral, or prescription, more than six out of 10 would have been interested in discussing FP at both baseline and endline.

Overall, health facilities have improved the provision of IUDs and injectables to clients seeking services other than FP since baseline. Compared to the baseline, more health facilities were providing the methods on the very same day they were requested. Most of the providers, regardless of facility type and city, reported that they routinely offer FP information to clients seeking antenatal care, delivery care, postnatal care, post-abortion care, child health services, or curative health services. The percentage of exit interview clients who received any FP information while seeking other health services ranged from 10.4 percent during curative care to 54.5 percent during postabortion care visits.

FP Counseling

Client-provider interactions are an important aspect of ensuring that clients are appropriately counseled on method choice, side effects, follow-up mechanisms, and that any questions they have are addressed. The data showed improvements in client-provider interactions in Machakos since baseline whereas in all other cities improvements were seen for some aspects of quality counseling whereas other categories saw no change or slight declines.

Provider Training

At endline, the percentage of providers who ever received in-service training on FP increased in public facilities as compared to the baseline. All cities had an increase from baseline to endline in in-service training on FP in public facilities, though in Kisumu at endline only about 50 percent of providers had ever received in-service training on FP. Patterns of in-service training on FP in private facilities were similar at baseline and endline.

By endline, the percentage of providers who had in-service training in general FP counseling skills showed an increase in Nairobi, Mombasa, and Machakos. In-service training in implants increased considerably from baseline to endline, with large increases in Machakos, Nairobi, and Mombasa.

Whole Site Training

In order to ensure all staff were trained on FP at health facilities, including doctors, nurses, administrative staff and cleaners, the Tupange program implemented whole site training at facilities where they worked; this strategy ensured that any staff member that a client came into contact with would have accurate knowledge and information about FP methods. Less than 50 percent of the facilities interviewed had ever participated in a whole-site training, but Tupange-supported facilities reported a higher percentage of receipt of whole site training as compared to non-Tupange facilities. Nearly one-third of the providers in all facilities reported that their facilities had participated in whole-site training, and four out of the ten providers reported participation in mentorship programs on FP. Tupange sponsored more than two-thirds of providers who participated in mentorship programs in Tupange-supported facilities and less than a quarter in non-Tupange facilities.

Community Outreach

The Tupange program worked in collaboration with health facilities on community outreach activities including the support and training of community health volunteers (CHV) and community events. Overall, a higher percentage of Tupange facilities than non-Tupange facilities had CHVs attached to them. Among all facilities with any CHVs, nearly all Tupange facilities and almost 80 percent of non-Tupange facilities had CHVs who received training on FP. Similarly, 89.9 percent of Tupange facilities and 76.2 percent of non-Tupange facilities had CHVs who provide FP commodities. About one quarter of the clients had been visited by a CHV during the year before the endline survey, with the exception of in Kakamega where approximately 41 percent had been visited. Among women who reported having been visited by a CHV, as much as 20 percent of women reported having ever received oral pills from CHVs, and about one quarter reported that they had ever received condoms from the CHV.

Less than half of all the facilities had outreach programs; a higher percentage of the Tupange facilities had an outreach program as compared to non-Tupange facilities. In some facilities, Marie Stopes/Tupange had supported clinical teams to visit health facilities in order to provide long-acting or permanent methods of FP. Nearly all of the Tupange facilities and about one-fifth of the non-Tupange facilities received such supportive visits at endline.

Methods Provision, Availability and Stocking

Overall, a higher percentage of public facilities than private facilities provided various FP methods at endline. Provision of long-acting and permanent methods (LAPM, consisting of IUD, implant, female sterilization, or male sterilization) increased in both public and private facilities at endline. There was a large increase in provision of implants across facility type and city, which was a focus of the Tupange program.

On average more than 80 percent of public facilities offered seven or more modern methods of FP, as compared to 50 percent of private facilities.

In Nairobi and Kakamega, irrespective of facility type, the percentage of facilities that had IUDs, implants, and injectables in stock increased or stayed the same since baseline. Overall, all health facilities were less likely to report stock-outs at endline than at baseline. Nevertheless, in the 30 days prior to the survey, most public facilities were more likely to experience stock-outs of emergency contraceptives, progestin-only pills, female condoms, and SDM than of other methods at endline. In private facilities, on the other hand, stock-outs were evenly distributed across methods and cities. Stock-outs in both public and private facilities had similar patterns at 30 days prior to

the survey and one year prior to survey. For the previous one-year period, the percentages were higher across cities and methods.

A component of the Tupange program was to facilitate the distribution and redistribution of contraceptive methods in order to ensure commodity security at both public and private health facilities. Overall, a higher percentage of facilities in Nairobi received an emergency distribution of FP methods than did facilities in the other cities in the three months prior to the survey; additionally, they participated in redistributing FP methods more than any other city.

Exposure to Tupange Demand Generating Activities

The Tupange program had an array of demand generating activities, including print media, television, radio, and outreach. Exposure to these demand generation activities were asked of exit interview clients.

About three quarters of clients across cities reported that they had heard or seen the word "Tupange" in the year prior to the exit interview survey; among these women, they had most frequently seen the logo on television, posters, health worker uniforms, and signs at health facilities.

Approximately one-third of exit interview clients reported having read any newspapers or magazines in the previous year. Among those, only about one-third reported having read articles related to the Tupange project. In the year prior to the survey, the majority of women across all cities had read or seen "celebrate life" posters, ranging from 55 percent in Kakamega to 65 percent in Kisumu. About half of the clients had seen or read "Tupange Imarisha Maisha" brochures, ranging from 40 percent in Machakos to 59 percent in Kisumu. More than a quarter of the women had seen or read the comic book *Shujaaz.*

Across cities, the *Jongo Love* radio program was listened to by less than a quarter of the clients who had listened to the radio three months prior to the survey. Among women who watched television in the previous three months, most of them (ranging from 89 percent in Mombasa to 95 percent in Kakamega) saw child birth spacing or FP information on television in the previous year.

Tupange-supported facilities are much more likely to have IEC materials than non-Tupange facilities. Demonstration models and samples of FP methods were the most widely available FP IEC materials across the facilities. Posters and clothing, caps, bags, lab coats, and aprons were also relatively common IEC materials.

Chapter 1: Introduction

Overview and Objectives of Tupange/MLE Study

The global reproductive health community requires strong evidence to support the expansion and development of family planning (FP) programs in areas with high unintended pregnancy and maternal and infant mortality. The Bill & Melinda Gates Foundation (BMGF)'s Reproductive Health (RH) strategy aims to reduce maternal and infant mortality and unintended pregnancy in the developing world by increasing access to high-quality and voluntary FP services. The Foundation's RH strategy is implemented in select countries through the Urban Reproductive Health Initiative (URHI). The URHI aims to increase modern contraceptive use in selected urban areas of three countries in sub-Saharan Africa (SSA)—Kenya, Senegal, and Nigeria—and in Uttar Pradesh, India.

In Kenya, the URHI is known as "Tupange," a Swahili word that means "let's plan." Tupange is being implemented by a consortium led by Jhpiego and including its partners, Marie Stopes International (MSI); the National Council for Population and Development (NCPD); Johns Hopkins Center for Communications Programs; and Pharm Access Africa Limited (PAAL). The Tupange project, is a six-year initiative that sought to increase the modern contraceptive prevalence rate by 20 percentage points in selected urban centers: Nairobi, Mombasa, Kisumu, Kakamega, and Machakos. Specifically, the objectives of the project were:

- To integrate high-quality FP services with maternal and newborn services,
- To improve the overall quality of FP services,
- To increase access to FP services for the urban poor through public-private partnerships and other private-sector approaches,
- To create sustained demand for FP services among the urban poor, and
- To create a supportive policy environment for ensuring access to FP supplies and services for the urban poor.

The Measurement, Learning & Evaluation (MLE) Project is the evaluation arm of the Kenya URHI (Tupange) and is implemented by the University of North Carolina at Chapel Hill (UNC-CH) in collaboration with the International Centre for Research on Women (ICRW) in India and IntraHealth International for the three SSA project countries, Kenya, Senegal, and Nigeria. MLE uses rigorous and state-of-the-art methods to evaluate the impact of the URHI on modern contraceptive use in diverse population groups. More specifically, MLE addresses the paucity of evidence for urban FP initiatives by:

1. Using a longitudinal design to ensure the highest possible standard of evidence with minimal disruption to program implementation,
2. Developing and using study tools and methods that permit generalization beyond the particular intervention areas and countries under study,
3. Using a strong program-monitoring framework to examine steps along the causal pathway and assess the plausibility of program effects on outcomes, and
4. Explicitly examining intra-urban differences in program impacts through comparison of slum and nonslum populations and of the wealthy and poor.

Baseline household data for the Kenya URHI were collected by the Kenya National Bureau of Statistics (KNBS) in five urban areas (Nairobi, Mombasa, Kisumu, Machakos, and Kakamega) from households, women, and men between September 2010 and November 2010. Individual-level data were collected from approximately 9,000 women ages 15–49 from the five urban areas and from approximately 2,500 men ages 15–59 from the three initial intervention sites (Nairobi, Mombasa, and Kisumu). In addition, a service delivery point (SDP) survey was undertaken by the Kenya Medical Research Institute Research Care and Training Program (KEMRI-RCTP) from August 2011 to November 2011, drawing responses from 286 facilities in the five cities. The SDP survey included a health facility audit for health facilities and pharmacies, provider interviews, and exit interviews.

The endline SDP survey was conducted in the five cities between October 2014 and November 2014. This report presents some of the key findings from the survey, which was designed by the MLE project and Tupange and executed by the KEMRI-RCTP.

The major objectives of the endline SDP survey were to:

1. Update the sampling frame for public sector health facilities (including specific verification of all facilities interviewed at baseline) through a physical audit and confirm existing and functional public facilities in all five cities;
2. Conduct health facility audits at all facilities included in the baseline survey (public and private), any additional facilities where Tupange was working that were not included at baseline, and any new public facilities in existence since baseline in each city;
3. Carry out a census of facilities in Kisumu, Machakos, and Kakamega cities;
4. Conduct provider interviews (four per facility or all providers where there are fewer) in facilities sampled for audit and client interviews (about 850 client interviews per city); and
5. Collect updated GPS points for all baseline facilities, current Tupange facilities, and any new additions to the frame.

Overview of Health Systems in Kenya

Kenya has struggled to build a health system that can effectively deliver quality services to its population. When compared globally, Kenya's health system was ranked 140 out of 191 countries (WHO, 2000). Access to health care varies widely throughout the country and is determined by numerous factors, with economic income being a major factor. The poor constitute approximately 52% of the Kenyan population (UNDP, 2009), which implies that they may have additional barriers to accessing health care. High fertility, high incidence of infectious diseases, poverty, and poor access to health services are some of the key factors contributing to the population's deteriorating health status and the country's poor ranking worldwide (NCAPD et al., 2011; KNBS, 2010).

Kenya's population stood at 38.6 million as per the last census, in 2009 (KNBS, 2010). Women make up slightly more than half of this population (KNBS & ICF Macro, 2010), and about 64 percent of the total population is under 24 years old (KNBS & ICF Macro, 2010). Kenya's current fertility rate is 3.9 live births per woman, and its annual population growth rate is 2.9 percent, with projections showing Kenya's population likely to more than double by 2040 (KNBS, 2015).

Numerous factors cause access to health-care services to vary widely between urban and rural areas and between the wealthy and the poor (Turin, 2010). At present, Kenya's urban population is estimated at 32 percent of the country's total population, with between 60 and 80 percent of these living in slums (UN-Habitat, 2008). Those who live in slums have limited access to basic health services as a result of poor provision of essential health infrastructure and services in these areas. Even though the contraceptive prevalence rate (CPR) is higher in urban than in rural areas (KNBS, 2010), 23 percent of the total demand for FP still remains unmet among urban slum dwellers (MLE & KNBS, 2011).

A 2010 review of the health situation in Kenya performed by the Ministry of Medical Services and the Ministry of Public Health and Sanitation revealed that improvements in health status have been marginal in the past few decades, and certain indicators have worsened (KPMG, 2013). The maternal mortality rate (MMR) and neonatal mortality rate (NMR) have worsened over the past few decades, while infant mortality rate (IMR) has only marginally improved (NCAPD et al., 2011).

The recently enacted Constitution of Kenya guarantees the right to the "highest attainable standard of health, which includes the right to reproductive health care service" (Republic of Kenya, 2010). A good health system delivers quality services to all people, when and where they need them. The exact configuration of services varies from country to country but in all cases requires a robust financing mechanism, a well-trained and adequately paid workforce, reliable information on which to base decisions and policies, and well-maintained facilities and logistics to deliver quality medicines and technologies. The largely unmet need for FP, particularly among urban slum dwellers, threatens the country's capacity to achieve the goals of the Kenya Vision 2030 development program, such as providing an efficient and high-quality health-care system with the best standards. It also justifies calls for

heightened attention to the country's FP program to ensure increased funding for and enhanced availability of its services, strengthening public-private partnerships to expand access to all who need FP services.

Organization of Health Care in the Devolved System

On August 4, 2010, 67 percent of Kenyan voters approved a new constitution in a constitutional referendum signed into law on August 27, 2010. Under the new constitutional dispensation, the two health ministries (Ministry of Medical Services and Ministry of Public Health and Sanitation) were merged in 2013, and subsequently the unified Ministry of Health (MOH) was devolved to the county level. The Kenya Health Policy 2012–2030 provides guidance to the health sector in terms of identifying and outlining the requisite activities in achieving the government's health goals (NIDI & APHRC, 2013). Devolution gives responsibility for services to the counties; this means the countiesraise their own revenues and have the authority to make investment decisions independent of the national government (KPMG, 2013)

The aim of devolving the health ministry was to promote access to health services throughout Kenya and address marginalization of low-potential areas. In the devolved system, health care is organized in a four-tier system (Kenya Health Policy, 2012–2030):

- Community health services: This level consists of all community-based demand creation activities, that is, the identification of cases that need to be managed at higher levels of care, as defined by the health sector.
- Primary care services: This level consists of all dispensaries, health centres and maternity homes for both public and private providers.
- County referral services: These are hospitals operating in and managed by a given county and that consist of district and subdistrict hospitals in the county; they include both public and private facilities.
- National referral services: This level consists of facilities that provide highly specialized services and includes all tertiary referral facilities.

The counties oversee the first three levels of care: community health services, primary care services, and county referral services. The national government oversees the national referral services.

Health Care Financing

Although budgetary allocations to the health sector in Kenya have maintained a nominal but steady rise, their share of the government's total budget has remained relatively constant at 4.5 percent, far below the declaration set in Abuja of 15 percent in September 2000 (IEA, 2014). This allocation is the lowest in the East Africa region (World Bank, n.d.). In addition, the funding allocation is biased in favor of secondary and tertiary institutions (DSW, 2011). Despite its important contribution to the Millennium Development Goals (MDGs), reproductive health-care resource allocation is very low. According to "Health Budgeting in Kenya: The Case of RH/FP 2010" (DSW, 2011), only Kshs 1.2 billion was dedicated to RH (FP and maternal and child health) out of a total health budget of Kshs 47 billion, with FP accounting for 22 percent of the RH expenditures. This bias in funding toward higher-level institutions, coupled with the low priority accorded to reproductive health, is reflected in the high total fertility (KNBS & ICF Macro, 2010).

Health care in Kenya is currently financed from three main sources: out of pocket (OOP) expenditures (households), government expenditures, and donors. Consumers are the largest contributors, representing approximately 35.9 percent.The Government of Kenya contributes 29.3% and donors contribute about 31% (Luoma et al., 2010). A survey conducted in 2007 showed that 38 percent of persons who were ill cited lack of money as a barrier to seeking health care (Ministry of Medical Services, 2009). The majority of OOP resources for RH were spent at health facilities. Public hospitals accounted for 36.4 percent of total household spending on RH. Among private health facilities, clinics and hospitals received 15 and 22.9 percent of household spending on RH, respectively (NIDI & APHRC, 2013). OOP payments are a barrier to access to health care, including RH care, and increase the likelihood of household impoverishment (NIDI & APHRC, 2013; WHO, 2000; Xu et al., 2010).

Human Resources for Health and Health Information Systems

Like most countries in Africa, Kenya suffers a shortage of health-care workers; the WHO has identified Kenya's shortage as "critical" (WHO, 2010). The WHO has set a minimum threshold of 23 doctors, nurses, and midwives per population of 10,000 as necessary for the delivery of essential child and maternal health services (Xu et al., 2010). Kenya's most recent ratio stands at 13 per 10,000.

This shortage is markedly worse in rural areas, where, as noted in a recent study by Transparency International, under-staffing levels of between 50 and 80 percent were documented at provincial and rural health facilities (Transparency International–Kenya, 2011). Many of these health-care workers exist at higher levels of service delivery due to better incentives (Ndetei, 2008), impairing service delivery across all levels of care.

Overview of Fertility and FP in Kenya

As early as 1968, Kenya became one of the first countries in SSA to develop a national population policy. This policy, however, was not implemented until the World Fertility Survey (WFS) of 1977 demonstrated that Kenya had one of the highest total fertility rates (TFR) in the world, reporting a TFR of eight children per woman for Kenya (APHRC, 2013). These findings led to increased policy and public attention toward the need for population interventions to address fertility issues and resulted in the creation of a national FP program. Indeed, the decline in fertility between 1977 and 1998, from 8.1 to 4.7 births per woman, was one of the most rapid declines that followed the WFS, coming as a result of Kenyan government investment. Fertility has continued to decline since then (CBS et al., 2004). It still remains high among the poorest, however, and varies markedly across the counties (APHRC, 2013).

The TFR plateaued, with 4.6 percent reported in the Kenya Demographic Health Survey (KDHS) 2008/09, a slight decrease from the 4.9 percent reported in KDHS 2003, and in 2014 declined to 3.9. Fertility remains very high among the poorest, at 6.4 births, in contrast to 2.8 births among the richest. Several KDHS reports also show differentials in fertility for urban and rural areas in Kenya.

Fertility rates differ for urban and rural areas and across regions in Kenya. In KDHS 2014, the TFR in rural areas (4.5 births) was significantly higher than in urban areas (3.1 births). These urban-rural differences in fertility rates are evident throughout all age groups, including adolescents, which illustrates the need to address the unmet need for FP among all age groups including the youth who are early in their child bearing years (APHRC, 2013).

The practice of FP in Kenya has increased steadily since the early 1980s, with the CPR for all FP methods reaching 58 percent in 2014 (KNBS & ICF Macro, 2015). There has been a sizeable increase in contraceptive use, from 39 percent of married women in 2003 using any method to 58 percent in 2014. Contraceptive methods trend analysis shows that the overall CPR is fueled by increased use of modern contraceptive methods. Between 2003 and 2008, use of modern contraceptive methods increased from 32 to 53 percent among women, while use of traditional methods over the same time period decreased from 8 to 5 percent. Despite the overall increase in CPR, the level of unmet need for FP remains high (MPHS & MMS, 2009). The baseline MLE survey of women in five urban areas (Nairobi, Mombasa, Kisumu, Machakos, and Kakamega) found that between 18 and 33 percent of married women still had an unmet need for FP (MLE, 2011).

National Reproductive Health Policy

Since the early 1990s there have been continuous efforts to increase access to RH services globally through several international initiatives. In September 2000, many countries of the world adopted the Millennium Declaration, a collective commitment to accelerate progress on human development, setting out eight MDGs, which they pledged to achieve by 2015. It was widely acknowledged that these goals could only be reached if there were significant improvements in RH, especially in the poorest developing countries. Most families in this part of the world still have more children than they want. Women especially suffer from a lack of means to control their fertility, and many die young from causes related to maternal health (UNFPA, 2003). Unfortunately many of the MDGs were not met by 2015, which led to the subsequent launch of the Sustainable Development Goals (SDG) in an effort for the world to continue to evaluate progress on key indicators that are related to improved health.

In 2007, a more comprehensive National Reproductive Health Policy (NRHP) was launched with the goal of enhancing the RH status of all Kenyans by increasing equitable access to RH services; improving quality, efficiency and effectiveness of service delivery; and improving responsiveness to client needs (DSW, 2011). The NRHP aims to reduce the unmet need for FP by improving the policy environment for FP services, as well as delivery, availability, and uptake in use of FP services.

The policy also has a mandate to improve integration of HIV/AIDS and RH information and services, as well as to promote use of information and services at all levels of health care. These efforts will contribute to the reduction of the HIV/AIDS burden and improved RH status of those infected and/or affected by HIV (KNBS & ICF Macro, 2010).

To operationalize the policy, the National Reproductive Health Strategy (NRHS, 1996) was developed. It identified several priority areas, namely, safe motherhood, maternal and neonatal health, FP, adolescent sexual and reproductive health, and gender issues (MMS, 2009). It aimed, and continues to aim, to increase CPR to 56 percent by 2015, meet 70 percent of the total FP demand, and contribute to the achievement of Vision 2030 and health-related MDGs (MMS, 2009). As evidenced by a CPR of 58 percent in the 2014 KDHS, the CPR goal was met by it's target date of 2015 (KNBS, 2015).

The NRHS ensures the interlinking of reproductive health with other development sectors through a multisectorial approach. With respect to the maternal and newborn child health agenda, this strategy is designed to ensure that every pregnancy is wanted and that all pregnant women, newborns, and infants have access to skilled care (MMS, 2009). The harmful impact of these needs remaining unmet is further compounded by a decline in the uptake of long-acting and permanent FP methods and the fact that uptake of FP services is lower among populations in the poorest wealth segments (KNBS & ICF Macro, 2010).

Chapter 2: Study Methodology

Survey Organization and Implementation

The Tupange/MLE Endline SDP survey was implemented by the KEMRI-RCTP. The MLE Project is led by UNC-CH in partnership with IntraHealth International in Kenya; MLE provided technical assistance and oversight for the SDP survey. The study was funded by the BMGF.

KEMRI-RCTP played a primary role in the planning and execution of the survey. In particular, they verified and aided in the development of a sampling frame for facilities, developed listing forms and listing protocols, validated and confirmed the sampled health facilities, recruited and trained interviewers and supervisors, translated and pretested the survey tools and methods, collected data, and carried out data entry and cleaning.

The listing and verification exercise was conducted to map the location of study facilities in order to assist in finding the facilities at the time of the audit. In Nairobi and Mombasa, a list of health facilities was chosen at baseline; these facilities were verified at endline and, when found, GPS coordinates were collected. In addition, facilities that were not in the baseline survey but had received the Tupange intervention were included in the endline survey. In Kisumu, Machakos, and Kakamega, a census of facilities providing FP and RH services in designated Tupange regions was carried out.

The KEMRI Ethics Review Committee and the Institutional Review Board at UNC-CH approved the survey's implementation in the five cities. The Ministry of Health provided approval letters to aid in facility entry for all public health facilities.

Sampling Frame Development

Sample of Health Facilities

All facilities that were in the baseline survey frame were eligible for inclusion in the endline survey. At baseline, the selection of facilities included varied from urban center to urban center. In Nairobi and Mombasa, the selection was made up of Tupange strategic facilities and facilities identified by women in the Individual Survey as locations where they go for FP methods and services (preferred providers). In Kisumu, the survey encompassed the Tupange strategic facilities plus all the other facilities in the District of Kisumu East. In Kakamega and Machakos, a census of FP, RH, and MCH facilities was conducted.

In addition, the endline survey also included other facilities where Tupange was working by the time of endline but not at baseline and any new public facilities. RCTP used MOH's records to compile a list of all new public facilities in each city. In addition, a new census of facilities was carried out in Kisumu, Machakos, and Kakamega. The combination of these lists was the basis for the master facility list. The health facilities included hospitals, health centers, dispensaries, private clinics, nursing/maternity homes, and faith-based and nongovernmental organization (NGO)-based health facilities.

With the support of MLE's quality assurance (QA) teams, the RCTP conducted a verification exercise of all the facilities from the baseline survey plus additional facilities as provided by MLE and Tupange. The listing indicated the name of the facility, the managing authority, the type of facility based on the new MOH classifications, the location, the landmark, if the facility was still open, its registration status, and GPS coordinates (three recorded per facility). In Kisumu, Machakos, and Kakamega, the RCTP conducted a new listing and mapping exercise to systematically verify the existence and location of facilities. The listers walked through each sublocation in a systematic manner starting from different ends, verifying facilities provided by MLE to list facilities in the area. They also used general knowledge, local point persons, assigned drivers, taxi cab drivers, and references from known facilities to locate and map unknown facilities.

Facility audits were undertaken in both public and private facilities that offer FP and maternal, newborn, and child health (MNCH) services. Table 2.1 shows in detail the number of facilities that were selected and that completed interviews for the facility audit only and the number of facilities selected and interviewed for both the facility audit and interviews with clients exiting the facility.

Table 2.1: Number of sampled facilities versus number of facilities surveyed

Number of facilities selected for facility audits and exit interviews versus number of facilities successfully interviewed at endline, Kenya, 2014

	Number of facilities selected		Number of facilities successfully interviewed	
City	Facility audit	Exit interview	Facility audit	Exit interview
Nairobi	174	56	173	56
Mombasa	81	38	79	38
Kisumu	65	38	65	37
Machakos	39	22	36	20
Kakamega	27	16	24	14
Total	**386**	**170**	**377**	**165**

Sample of Providers

Provider interviews were undertaken in both public and private facilities offering FP and MNCH services, as well as among other services where FP integration may occur, such as Prevention of Mother-to-Child Transmission (PMTCT), postpartum care, and/or postabortion care services. The provider interviews were completed in facilities sampled for the audit. Four providers from all relevant departments in each of the selected sites were interviewed. In smaller facilities with less than four providers, the goal was to interview all providers. On the day of the survey, a comprehensive list of providers currently on duty, by cadre and department (if applicable), were recorded by the field team. If the facility had more than four providers offering services that day in FP, MNCH, or other relevant departments, all providers in the relevant departments were listed, and four were selected at random, with the goal of interviewing multiple provider types (e.g., doctor, clinical officer, nurse, etc.). Selected providers were approached and told about the study through a brief description and the reading of the consent form. Providers who were willing to participate were asked to come to a separate room, to sign the consent form, and to complete the interviewer-led survey. A total of 983 providers were interviewed.

Sample of Exit Interviews

At endline, RCTP carried out exit interviews in all facilities where exit interviews took place at baseline and in new Tupange strategic facilities. Women aged 15–49 years who received FP services, child health services, postpartum care, PMTCT, postabortion care, and/or other potential integration services at selected health facilities on the day of the interview were eligible for the survey. MLE apportioned 25 women per selected facility in Nairobi and Mombasa and 30 women per selected facility in Kisumu, Machakos, and Kakamega. The interview team allowed a maximum of five days at each facility to complete 25–30 client exit interviews. The enumerators liaised with the providers assigned to RH clinics in order to inform women accessing the aforementioned services about the exit interviews, and that they may be approached for interview. The enumerators stationed themselves strategically in the health facilities and tactfully approached women when they were exiting. The enumerators directed the women to a private place, received informed consent from them for the interview, and conducted the interview accordingly. Enumerators targeted about half of the exit interviews to be with FP clients; the remaining 50 percent were MNCH and other potential integration clients. A total of 4,861 women were interviewed across the five cities.

Data Collection Instruments

The 2014 facility-based endline survey instruments included a health facility audit questionnaire, service provider interview questionnaire, and women exit interview questionnaire. These instruments were similar in content to the ones used in the baseline survey, with the exception of a few additional questions. The questionnaires were developed by MLE in consultation with Tupange, KEMRI-RCTP, and other stakeholders. The health facility audit and the service provider interview questionnaires were administered in English. The women's exit questionnaire was translated into Kiswahili, Dholuo, and Kamba languages for respondents who did not speak English. The Kiswahili and English versions of the questionnaires were used in all five cities. In addition, the Dholuo version was used in Kisumu, while the Kamba version was used in Machakos. The translated questionnaires were also pretested to detect possible errors during the translation process.

A manager at each public and private SDP included in the study was interviewed to obtain general information about the site. The health facility audits were also used to list all the eligible service providers in the facility. Further, the facility in-charge was allowed to take part in the service provider interview depending on the eligibility and sampling process for providers.

Training and Supervision of Field Interviewers

KEMRI-RCTP recruited the data collectors and supervisors. Candidates were selected from among clinical officers, medical personnel, and social scientists.

The pilot survey training meeting was held in Homabay at Twin Towers Hotel from August 27 to 30, 2014. Most important, the pilot survey provided room for necessary changes and revisions to the study documents before final submission to the ethical review board and implementation. The draft questionnaires and the methodology were subjected to a pretest in six facilities in Homabay County (a nonsurvey area).

The pilot training participants consisted of KEMRI-RCTP and MLE staff members including principal investigators (PI), the survey coordinator, a monitoring and evaluation (M&E) specialist, clinicians, enumerators, as well as MLE working as regional technical coordinators and QA specialists. This team of trainers later conducted the final enumerators' training and supervised the implementation of the actual survey.

The second training was done in Nairobi at the KEMRI-RCTP board room and consisted of those research assistants who would be involved in the listing/verification of health facilities. The training was done between September 1 and 2, 2014, followed by the actual listing/verification exercise from September 3 to 12, 2014. City managers for the field data collection participated in this exercise to allow them to get familiar with the geographical and facility layouts and also to create rapport prior to the actual data collection.

The main enumerators' training was done in Thika town from Monday, September 29, to Saturday, October 4, 2014. All the recruited research assistants from Mombasa, Machakos, Nairobi, Kisumu, and Kakamega took part in the training. Six additional reserve enumerators, one from every city and two from Nairobi, were also trained to offer backup services if the need arose. Additional city-level MLE QA staff were also trained. The trainers were program and technical staff from RCTP and MLE. This training covered interviewing techniques, research ethics, FP services provision in Kenya, and a thorough review of the data collection instruments. Specialized topics were presented during plenary sessions, while more in-depth training on questionnaires and interviewing skills was provided through class presentations, mock interviews, and role plays. Trainees were divided according to the questionnaires they would be administering in the field. For example, women client exit interviewers, service provider interviewers, and auditors were all placed in three respective classes. This provided ample time for in-depth discussions and mastery of the data collection instrument before leaving for the field. Two days were dedicated to field pretest activities in 12 selected health facilities in Thika. The fifth day of the training was used to offer extra training to city managers on their specific duties as supervisors and how to organize and direct the fieldwork procedures. They were also trained to manage logistical issues while in the field. Throughout the training, the field editors spent time with the data manager and learned how to edit completed questionnaires while in the field.

At the end of the training, a total of six teams, each comprising a city manager, a field editor, and male and female research assistants, were sent to the field. Each of the cities had one such team, except for Nairobi, which had two teams because of the high number of health facilities to be visited and interviews to be completed.

Data Collection

Prior to the commencement of data collection, KEMRI-RCTP obtained letters of approval from ethical review boards, the MOH, and the respective county health officials and delivered them to the health facilities. This process was very helpful in increasing the response rates and cooperation from the facility supervisors.

The actual data collection started on Monday, October 6, 2014, and was completed on Friday, November 14. The survey team was organized in such a way that each city had a city manager to help in field coordination and supervision. The city managers received their assignments from the national survey coordinator and directly reported all field-related issues to him. They ensured

that all the field data collection items were in place, the set targets were met, and the protocol was followed. The research assistants and field editors answered directly to the city managers.

Each interviewer was assigned a specific questionnaire type and a facility to visit each day. Health facility audits were done by trained health-care interviewers. To ensure high data quality, each facility auditor performed a maximum of two audits in a day. Female research assistants conducted the client exit interviews.

All the interviewers were required to check their questionnaires for completeness immediately after the interview and before handing it to the field editor. The field editor cross-checked sections of the questionnaires as a quality control measure. Any mistake identified was returned to the interviewer immediately for correction. The city manager and the MLE quality assurance (QA) teams also checked the completed questionnaires and conducted random checks to ensure that high-quality data were gathered by the field teams.

The reviewed questionnaires were then packed and sent to the central office, where the office editors would also go through the received questionnaires for completeness and accuracy before data entry. Any mistake caught by the office editors that had not been identified and addressed by the field editor, city manager, or QA was returned to the field for correction.

Data Processing

Data processing was done in a central office in Kisumu. All the questionnaires from the field were sent to this office. The data processing team consisted of a data manager, three office editors, and 12 data clerks. Questionnaires from the field were received by the data manager and given to the office editors to counter-check what was sent with the accompanying accountability forms from the field. They would then record the received number of questionnaires, and any discrepancy was communicated to the field team immediately. There was a separate office for receiving and editing the questionnaires.

Both the editors and data clerks received special training for their roles from October 21 to 24, 2014. The training and technical assistance was provided by KEMRI-RCTP and the MLE team. The actual data entry exercise began on October 27, 2014, and ran through December 5. The CS pro data capture program designed by MLE was used to process the data.

Chapter 3: Survey Results

Overview of the Audits and Interviews

A total of 377 facilities were audited in the endline survey. Of these facilities, 110 were public and 267 were private. Nairobi had the highest number of facilities (173), followed by Mombasa and Kisumu, with 79 and 65 facilities respectively. In Machakos, 36 facility audits were conducted, while in Kakamega there were 24. A total of 966 service providers were interviewed in public facilities and 575 in private facilities. A total of 4,861 women were interviewed from the selected facilities in the five cities. Table 3.1 summarizes the total number of interviews carried out for health facilities (public and private), health providers, and women client exit interviews in each city.

Background Characteristics of Health Facilities, Providers, and Clients

Background Characteristics of Health Facilities

The facility audit included facilities of a range of types, including hospitals, health centers, maternity homes, clinics, and dispensaries. Clinics were predominant across cities at both baseline and endline. Approximately the same numbers of public and private facilities were interviewed at baseline and endline. Most of the audited facilities were managed privately; at endline, the percentage in the private sector ranged from 52.3 percent in Kisumu to 67.1 percent in Mombasa. Across cities, up to 20 percent of the facilities were run by NGOs or faith-based organizations (FBOs). Table 3.2 provides summary information on distribution of facilities by background characteristics at baseline and endline.

Demographic Characteristics of Exit Interview Clients

A total of 4,861 women who received health services in the selected health facilities were interviewed to assess quality of care, interaction with service providers, method use, level of satisfaction, and their socioeconomic characteristics. Table 3.3 presents the demographic characteristics of the women who participated in the client exit interviews. More than three-fourths of the women seeking health services were between ages 20 and 34. Kisumu had a larger percentage of youth (age 15-19) in their interview sample at 13.7 percent. Across all cities, most women interviewed were married, and around 80 percent had three or fewer children. A majority of the women were Protestant/other Christians and Catholics, although the share of Muslim was considerably higher in Mombasa than in the other cities. Most of the respondents had completed secondary school, ranging from 48.1 percent in Mombasa to 67.6 percent in Kakamega.

Demographic Characteristics of Health-Care Providers

Out of the 377 facilities visited, a total of 966 providers were interviewed. More health-care providers were interviewed in private facilities (575) than in public facilities (391). The mean age of the providers across all cities was above mid-30s, and the mean number of years working as a health-care provider was less than 16 years. Service providers in Kakamega were much

Table 3.1: Number of health facility audits and interviews at endline

Number of health facility audits, provider interviews, and client exit interviews, by city, Kenya, 2014

	Health Facilities		Provider Interviews		Number of exit clients interviewed
City	Number of public facilities interviewed	Number of private facilities interviewed	Number of public facility providers interviewed	Number of private facility providers interviewed	
Nairobi	52	121	185	247	1602
Mombasa	22	57	83	128	1162
Kisumu	18	47	67	131	1158
Machakos	10	26	27	41	522
Kakamega	8	16	29	28	417
Total	**110**	**267**	**391**	**575**	**4861**

Table 3.2: Background characteristics of health facilities at baseline and endline

Percentage distribution of health facilities audited by background characteristics, by city, Kenya, 2010, 2014

Characteristic	Nairobi		Mombasa		Kisumu		Machakos		Kakamega	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Type of facility										
Hospital	12.8	11.0	15.0	10.1	16.7	21.5	10.0	8.3	7.7	8.3
Health center	32.1	26.6	6.7	11.4	16.7	16.9	0.0	5.6	7.7	8.3
Maternity home	8.3	6.9	3.3	5.1	5.6	4.6	3.3	2.8	11.5	12.5
Clinic	37.6	48.0	60.0	59.5	37.0	41.5	70.0	61.1	50.0	50.0
Dispensary/other	9.2	7.5	15.0	13.9	24.1	15.4	16.7	22.2	23.1	20.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Managing authority										
Public	37.6	30.1	26.7	27.8	33.3	27.7	16.7	27.8	30.8	33.3
NGO/FBO*	18.3	15.6	6.7	5.1	18.5	20.0	6.7	8.3	0.0	0.0
Other private	44.0	54.3	66.7	67.1	48.1	52.3	76.7	63.9	69.2	66.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of facilities	**109**	**173**	**60**	**79**	**54**	**65**	**30**	**36**	**26**	**24**

*NGO= nongovernmental organization; FBO= faith-based organization

older and had spent more years working as a health provider than those in the other cities. A majority of the providers were interviewed in clinics, ranging from 29.8 percent in Kakamega to 45 percent in Mombasa, although considerable percentages of providers were interviewed in hospitals and health centers.

More than half of the service providers were female. More than one-third of them were registered nurses, ranging from 36.8 percent in Kakamega to 49.3 percent in Nairobi. Detailed results of provider distribution by demographic characteristics are presented in Table 3.4.

Services Sought by Clients and Services Offered by Health Facilities

Services Sought

Table 3.5 shows the percentage distribution of exit clients by main services they were seeking on the day of the survey by city at baseline and endline. Across all cities, at both baseline and endline, a combination of FP services and curative services accounted for most visits. Other main reasons cited for facility visits included antenatal care, growth monitoring, and child immunization. Only visits to seek FP services showed an increase across cities since baseline, though this may be due to an increased focus on interviewing FP exit clients. With the exception of Machakos, where more clients were interviewed at private facilities, more than half of the clients were interviewed in public health facilities at baseline and endline. The percentage of exit interview clients who sought delivery services, postnatal care, postabortion care, and HIV-related services remained very low at endline across all cities; this may be because there are fewer of these types of clients or they are more difficult to capture with exit interviews.

Health Services Offered

Overall, MNCH health services offered by public facilities increased since baseline. Regardless of facility type and city, by endline over 60 percent of the health facilities reported that they offered FP services, antenatal care, HIV care, and STI services. Postabortion care and maternal care/delivery services were the least provided services across all cities at baseline and endline. Tables 3.6a and 3.6b present the percentage of facilities that offer specific health services by city and managing authority.

Table 3.3: Demographic characteristics of exit interview clients at endline

Percentage distribution of exit interview clients at high volume/strategic sites by age, marital status, number of children, religion, and education, by city, Kenya, 2014

	Clients				
	Nairobi	Mombasa	Kisumu	Machakos	Kakamega
Age					
15–19	5.6	6.1	13.7	3.6	7.4
20–24	38.3	30.0	33.9	22.6	30.0
25–29	33.5	34.3	29.8	29.3	29.3
30–34	15.4	19.3	12.8	24.7	18.2
35–39	5.5	6.8	7.1	13.0	8.2
40–44	1.6	2.6	2.3	5.0	4.3
45–49	0.2	0.9	0.3	1.7	2.6
Marital status					
Never married	9.6	7.1	19.5	15.7	20.4
Married/living together	87.4	87.4	75.0	80.5	73.4
Separated/divorced	2.7	4.4	2.9	3.4	4.6
Widowed	0.4	1.1	2.6	0.4	1.7
Number of living children					
No children	7.6	8.5	14.2	10.2	21.1
1 child	41.6	32.7	30.7	35.2	28.3
2 children	30.0	29.7	28.4	26.8	24.2
3 children	13.5	15.5	15.6	16.7	12.5
4 children	4.9	8.2	6.9	7.5	5.5
5 children	1.4	2.6	1.8	1.5	3.6
6+ children	0.9	2.8	2.1	2.1	3.8
Missing	0.0	0.1	0.2	0.0	1.0
Religion					
Catholic	31.4	19.9	30.6	47.3	30.5
Protestant/other Christian	64.9	50.2	63.3	51.5	65.2
Muslim	2.5	28.8	4.4	1.1	3.8
Traditional/other	0.5	0.1	1.1	0.0	0.2
No religion	0.7	0.9	0.3	0.0	0.2
Missing	0.1	0.1	0.3	0.0	0.0
Education					
No education	0.9	5.5	0.8	0.8	2.6
Primary incomplete	11.4	16.0	16.1	6.3	12.5
Primary complete	25.5	30.3	24.1	32.4	16.8
Secondary or higher	62.1	48.1	59.0	60.5	67.6
Missing	0.1	0.1	0.0	0.0	0.5
Number of exit interview clients	**1602**	**1162**	**1158**	**522**	**417**

Table 3.4: Demographic characteristics of providers at endline

Mean age, mean service years, and percentage distribution of providers by religion, gender, qualification, managing authority, and type of facility, according to city, Kenya, 2014

	Providers				
	Nairobi	Mombasa	Kisumu	Machakos	Kakamega
Mean age	37.9	37.5	35.5	38.3	42.1
Mean number of years working as a health-care provider	13.1	12.3	9.8	13.1	15.9
Religion					
Catholic	28.7	26.5	23.7	33.8	22.8
Protestant/other Christian	67.6	60.7	73.2	64.7	71.9
Muslim	2.8	12.8	2.5	1.5	1.8
No religion	0.0	0.0	0.0	0.0	3.5
Missing	0.9	0.0	0.5	0.0	0.0
Gender					
Male	24.8	34.1	34.3	30.9	42.1
Female	75.2	65.9	65.7	69.1	57.9
Qualification					
Specialist/medical officer	0.7	2.8	8.1	5.9	15.8
Clinical officer	17.1	23.7	17.2	22.1	17.5
Registered nurse	49.3	41.7	40.9	47.1	36.8
Enrolled community nurse	25.7	14.2	10.6	13.2	17.5
Community health extension worker (CHEW)	0.7	0.5	1.0	0.0	1.8
VCT/HTC counsellor	0.9	5.2	13.6	7.4	7.0
Other	5.6	11.8	8.6	4.4	3.5
Managing authority					
Public	42.8	39.3	33.8	39.7	50.9
Private	57.2	60.7	66.2	60.3	49.1
Type of facility					
Hospital	13.2	15.2	27.8	17.6	10.5
Health center	38.7	15.2	19.2	7.4	14.0
Maternity home	7.9	5.7	3.0	5.9	15.8
Clinic	32.9	45.0	33.8	41.2	29.8
Health post/dispensary/other	7.4	19.0	16.2	27.9	29.8
Total number of provider interviews	**432**	**211**	**198**	**68**	**57**

In Mombasa, the percentage of public facilities that offered various health services increased across services since baseline. In Kakamega and Machakos, the percentage of public facilities that offered maternal care and delivery services increased considerably from 12.5 percent to 75 percent and from 20 percent to 60 percent, respectively. In provision of tuberculosis (TB) screening, postabortion care, and PMTCT, disparities were found in the percentage of public to private facilities. For example, provision of postabortion care at endline in Mombasa public facilities was 36.4 percent versus 64.9 percent in private facilities; in Machakos, this type of care was available at 30 percent of public facilities versus 61.5 percent of private facilities; and in Nairobi, 32.7 percent of public facilities versus 56.2 percent of private facilities offered postabortion care. Similar distinctions between public and private were observed at baseline for these services.

Integration of MNCH and FP Services

Clients Receiving Integrated FP Information or Services

One of Tupange's key activities is to integrate quality FP with MCNH, HIV/AIDS, postpartum, and postabortion care programs to increase the use of modern contraceptives among Kenya's urban population. FP information or services received by the clients while

Table 3.5: Services sought by exit interview clients at baseline and endline

Percentage distribution of exit interview clients at high volume/strategic sites by main service client was seeking and by managing authority, according to city, Kenya, 2011, 2014

	Nairobi		Mombasa		Kisumu		Machakos		Kakamega	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Main service client was seeking										
Family planning	47.0	48.4	22.8	42.1	21.8	32.1	30.6	39.8	20.8	35.5
Antenatal care	12.6	9.6	12.0	13.5	8.1	11.7	8.7	7.7	10.6	10.3
Delivery services	0.4	0.0	0.1	0.3	1.6	0.2	0.4	0.4	1.1	0.2
Postnatal care	1.2	0.5	0.2	0.7	2.3	1.5	1.6	0.4	0.7	0.0
Postabortion care	0.1	0.0	0.3	0.3	0.3	0.3	0.2	0.2	0.0	0.5
Growth monitoring	11.6	16.2	7.7	12.2	8.0	9.1	6.9	10.9	0.9	3.6
Child immunization	14.8	16.2	22.1	14.0	20.3	10.3	5.4	12.5	12.6	9.6
STI and HIV/AIDS management	0.9	0.4	3.5	0.7	4.2	2.0	0.2	0.4	0.0	1.2
Curative services	11.0	7.9	29.1	15.3	30.4	30.5	43.1	23.8	49.7	36.0
HIV testing and counseling	0.1	0.3	0.9	0.3	1.4	1.2	0.2	3.8	0.9	1.0
Other	0.3	0.6	1.1	0.5	1.6	1.2	2.7	0.2	2.7	2.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Managing authority										
Public	77.7	76.2	63.0	66.2	56.8	50.5	35.3	44.6	51.5	50.4
Private	22.3	23.8	37.0	33.8	43.2	49.5	64.7	55.4	48.5	49.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of client exit interviews	**1397**	**1602**	**881**	**1162**	**1053**	**1158**	**448**	**522**	**443**	**417**

Table 3.6a: Health services offered at baseline and endline

Percentage of facilities that offer specific health services, by city and managing authority, Kenya, 2011, 2014

City and managing authority	FP counseling & services		Antenatal care		Maternal care/ delivery service		Postnatal care		Postabortion care		Child health*	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Nairobi												
Public facility	100.0	100.0	97.6	98.1	29.3	32.7	97.6	90.4	34.1	32.7	100.0	100.0
Private facility	94.1	95.9	94.1	92.6	51.5	49.6	92.6	83.5	54.4	56.2	94.1	94.2
Mombasa												
Public facility	100.0	100.0	100.0	100.0	56.3	63.6	100.0	100.0	31.3	36.4	100.0	100.0
Private facility	97.7	98.2	100.0	94.7	61.4	56.1	95.5	87.7	70.5	64.9	95.5	96.5
Kisumu												
Public facility	100.0	100.0	94.4	100.0	38.9	55.6	94.4	100.0	27.8	44.4	100.0	100.0
Private facility	83.3	74.5	86.1	78.7	22.2	21.3	75.0	72.3	58.3	40.4	83.3	89.4
Machakos												
Public facility	80.0	100.0	80.0	100.0	20.0	60.0	80.0	90.0	40.0	30.0	80.0	100.0
Private facility	96.0	88.5	64.0	84.6	12.0	15.4	44.0	65.4	52.0	61.5	68.0	88.5
Kakamega												
Public facility	100.0	87.5	87.5	87.5	12.5	75.0	75.0	75.0	50.0	62.5	87.5	87.5
Private facility	66.7	75.0	77.8	75.0	44.4	37.5	72.2	62.5	55.6	50.0	72.2	56.3

*Child health includes child immunization and growth monitoring.

Table 3.6b: Health services offered at baseline and endline

Percentage of facilities that offer specific health services, by city and managing authority, Kenya, 2011, 2014

City and managing authority	HIV testing & counseling		TB screening		Early detection and treatment of STI		PMTCT**		Number of facilities	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Nairobi										
Public facility	97.6	96.2	78.0	78.8	90.2	86.5	97.6	98.1	41	52
Private facility	89.7	91.7	32.4	26.4	91.2	95.9	66.2	53.7	68	121
Mombasa										
Public facility	93.8	100.0	93.8	100.0	93.8	95.5	93.8	100.0	16	22
Private facility	86.4	96.5	31.8	35.1	100.0	93.0	61.4	50.9	44	57
Kisumu										
Public facility	100.0	100.0	66.7	77.8	100.0	94.4	88.9	100.0	18	18
Private facility	77.8	83.0	50.0	53.2	91.7	91.5	47.2	51.1	36	47
Machakos										
Public facility	100.0	100.0	80.0	70.0	100.0	100.0	40.0	100.0	5	10
Private facility	88.0	80.8	48.0	50.0	96.0	84.6	32.0	46.2	25	26
Kakamega										
Public facility	87.5	100.0	62.5	100.0	87.5	87.5	87.5	87.5	8	8
Private facility	61.1	62.5	27.8	25.0	94.4	68.8	44.4	37.5	18	16

**PMTCT = Prevention of mother-to-child transmission

seeking other health services, as reported in the exit interviews, is presented in Table 3.7. Integration of FP information into antenatal care, delivery services, child care, and curative services decreased since baseline. Only the percentage of women who received FP information during postabortion and postnatal services increased since baseline. During postnatal care, the percentage of women who received FP information increased from 20.8 to 28.6 percent, and during postabortion care, the corresponding percentage increased from 37.5 to 54.5 percent. However, a large percentage of women who sought these postnatal care and postabortion services did not receive any method, referral, or prescription during their visits at 88.6 percent and 72.7 percent, respectively.

More than six out of 10 women who were not using FP and who did not receive a method, referral, or prescription would have been interested in discussing FP at both baseline and endline.

Facilities Providing Integrated FP Information or Services

The usual practice at a facility for a woman who comes mainly for other services but is also interested in FP information was assessed in the audited facilities. Tables 3.8 and 3.9 summarize and compare the integration of FP services into other health services by facility type and city at baseline and endline (at baseline no data was collected on delivery care). Overall, health facilities have improved the provision of IUDs and injectables to clients seeking services other than FP. Compared to the baseline, more health facilities were providing the methods on the very same day they were requested. As reported by the facility audit, injectables were more commonly provided in many health facilities than IUDs on the same day for a woman who had come primarily for other services. Reported same-day provision of IUDs for a woman who was interested saw substantial improvement at endline across cities and health services in both public and private facilities. Figure 3.1 shows that by endline more private facilities were always offering injectables on the same day during postnatal visits.

Providers Offering Integrated FP Information or Services

Integration of FP services with other health services was also assessed at the service provider level. Service providers were asked if they routinely offer

Figure 3.1: Private facilities that provide injectables during postnatal services at baseline and endline

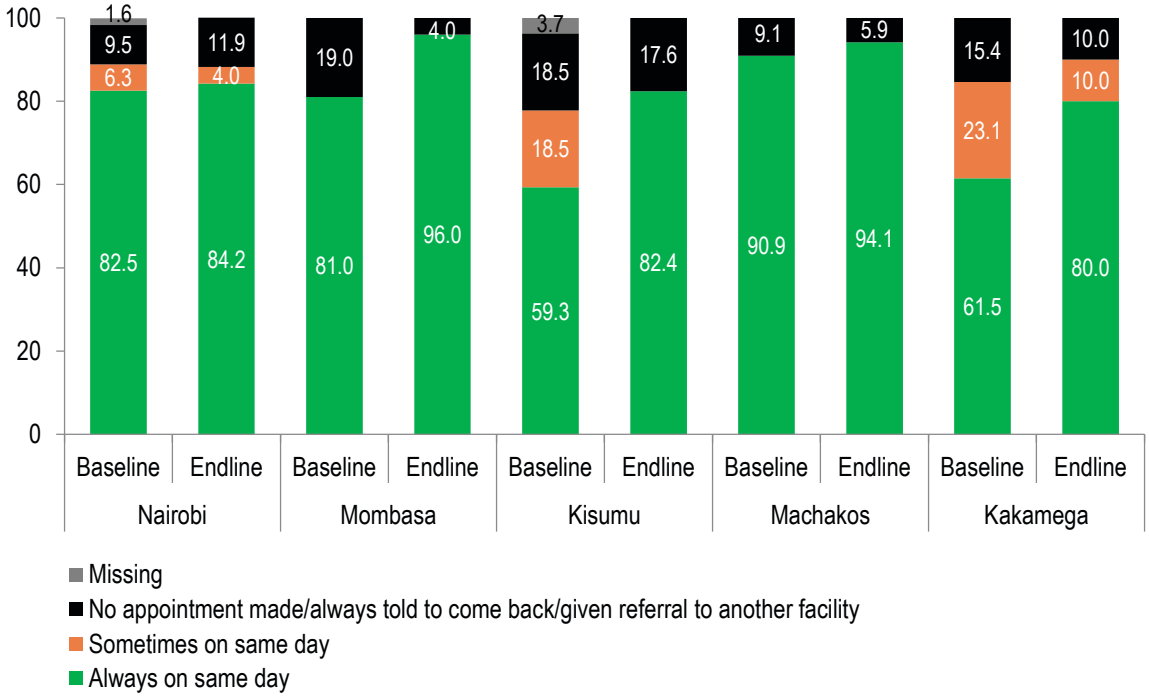


Table 3.7: Integration of services at baseline and endline

Percentage of exit interview clients at high volume/strategic sites receiving FP information or services by main service the client was seeking, Kenya, 2011, 2014

	Main service client was seeking											
	Antenatal care		Delivery services		Postnatal care		Postabortion care		Child health		Curative care	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Percentage who received any information about FP												
Yes	18.3	14.7	36.7	33.3	20.8	28.6	37.5	54.5	20.4	16.8	12.9	10.4
No	81.7	85.3	63.3	66.7	79.2	71.4	62.5	45.5	79.6	83.2	87.1	89.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Percentage who received FP during visit												
Method	0.0	0.4	0.0	0.0	1.9	0.0	0.0	9.1	3.2	1.6	0.5	0.3
Referral	0.0	0.2	0.0	0.0	1.9	0.0	0.0	0.0	1.0	0.6	0.4	0.0
Prescription	0.2	0.0	3.3	0.0	1.9	0.0	25.0	0.0	0.8	0.1	0.2	0.0
Already using FP	0.0	0.6	0.0	0.0	28.3	11.4	12.5	18.2	38.5	48.7	36.7	44.1
Received nothing	99.6	98.9	96.7	100.0	66.0	88.6	62.5	72.7	56.4	49.0	62.0	55.6
Missing	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.1	0.1	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of exit interview clients	453	529	30	9	53	35	8	11	1048	1225	1143	932
Among clients who were not already using FP and who did not receive a method, referral or prescription												
Percentage who would have been interested in discussing FP with provider	66.7	62.5	79.3	66.7	80.0	77.4	80.0	62.5	83.1	78.3	70.5	63.5
Percentage who would have accepted a method if the provider had offered it	23.1	18.7	41.4	33.3	48.6	25.8	60.0	25.0	51.6	40.8	28.1	24.1
Number of exit interview clients who were not already using FP and who did not receive a method, referral, or prescription	**451**	**523**	**29**	**9**	**35**	**31**	**5**	**8**	**591**	**600**	**709**	**518**

Table 3.8: Integration of services at baseline and endline

Percentage of distribution of facilities that provide delivery and postnatal care services, by practices used to integrate FP counseling, according to city and managing authority, Kenya, 2011, 2014

City and managing authority	Percentage of facilities that provide method during delivery care services								No. of facilities that provide delivery services	Percentage of facilities that provide method during postnatal care services								No. of facilities that provide postnatal care
	IUD				Injectable					IUD				Injectable				
	Always on same day	Sometimes on same day	Not on same day*	Missing	Always on same day	Sometimes on same day	Not on same day*	Missing		Always on same day	Sometimes on same day	Not on same day*	Missing	Always on same day	Sometimes on same day	Not on same day*	Missing	
Nairobi baseline																		
Public facility	NA	NA	NA	NA	NA	NA	NA	NA	NA	65.0	5.0	25.0	5.0	85.0	5.0	5.0	5.0	40
Private facility	NA	NA	NA	NA	NA	NA	NA	NA	NA	44.4	11.1	42.9	1.6	82.5	6.3	9.5	1.6	63
Nairobi endline																		
Public facility	47.1	11.8	41.2	0.0	47.1	5.9	47.1	0.0	47	72.3	10.6	17.0	0.0	87.2	4.3	8.5	0.0	47
Private facility	50.0	3.3	46.7	0.0	56.7	1.7	41.7	0.0	101	66.3	5.9	27.7	0.0	84.2	4.0	11.9	0.0	101
Mombasa baseline																		
Public facility	NA	NA	NA	NA	NA	NA	NA	NA	NA	31.3	0.0	56.3	12.5	75.0	0.0	12.5	12.5	16
Private facility	NA	NA	NA	NA	NA	NA	NA	NA	NA	42.9	7.1	47.6	2.4	81.0	0.0	19.0	0.0	42
Mombasa endline																		
Public facility	64.3	0.0	35.7	0.0	42.9	0.0	57.1	0.0	22	72.7	4.5	22.7	0.0	90.9	0.0	9.1	0.0	22
Private facility	46.9	6.3	46.9	0.0	53.1	3.1	43.8	0.0	50	72.0	10.0	18.0	0.0	96.0	0.0	4.0	0.0	50
Kisumu baseline																		
Public facility	NA	NA	NA	NA	NA	NA	NA	NA	NA	29.4	0.0	58.8	11.8	88.2	0.0	0.0	11.8	17
Private facility	NA	NA	NA	NA	NA	NA	NA	NA	NA	29.6	11.1	51.9	7.4	59.3	18.5	18.5	3.7	27
Kisumu endline																		
Public facility	60.0	20.0	20.0	0.0	60.0	0.0	40.0	0.0	18	44.4	11.1	44.4	0.0	94.4	0.0	5.6	0.0	18
Private facility	50.0	0.0	50.0	0.0	60.0	0.0	40.0	0.0	34	47.1	5.9	47.1	0.0	82.4	0.0	17.6	0.0	34
Machakos baseline																		
Public facility	NA	NA	NA	NA	NA	NA	NA	NA	NA	25.0	0.0	75.0	0.0	100.0	0.0	0.0	0.0	4
Private facility	NA	NA	NA	NA	NA	NA	NA	NA	NA	81.8	0.0	18.2	0.0	90.9	0.0	9.1	0.0	11
Machakos endline																		
Public facility	66.7	0.0	33.3	0.0	83.3	0.0	16.7	0.0	9	55.6	0.0	44.4	0.0	100.0	0.0	0.0	0.0	9
Private facility	75.0	0.0	25.0	0.0	75.0	0.0	25.0	0.0	17	70.6	0.0	29.4	0.0	94.1	0.0	5.9	0.0	17
Kakamega baseline																		
Public facility	NA	NA	NA	NA	NA	NA	NA	NA	NA	50.0	16.7	33.3	0.0	100.0	0.0	0.0	0.0	6
Private facility	NA	NA	NA	NA	NA	NA	NA	NA	NA	38.5	15.4	46.2	0.0	61.5	23.1	15.4	0.0	13
Kakamega endline																		
Public facility	16.7	33.3	50.0	0.0	0.0	0.0	100.0	0.0	6	50.0	16.7	33.3	0.0	50.0	16.7	33.3	0.0	6
Private facility	16.7	0.0	83.3	0.0	16.7	0.0	83.3	0.0	10	70.0	0.0	30.0	0.0	80.0	10.0	10.0	0.0	10

*No appointment made, always told to come back, given referral to another facility, given referral to another department, given no information or referral

NA = No data available

Table 3.9: Integration of services at baseline and endline

Percentage distribution of facilities that provide child health and STI/HIV care services, by practices used to integrate FP counseling according to city and managing authority, Kenya, 2011, 2014

City and managing authority	Percentage of facilities that provide method during child health services								No. of facilities that provide child health services	Percentage of facilities that provide method during HIV testing and counseling, TB screening, STI detection and treatment and/or PMTCT services								No. of facilities that provide HIV testing and counseling, TB screening, STI detection, and treatment and/or PMTCT services
	IUD				Injectable					IUD				Injectable				
	Always on same day	Sometimes on same day	Not on same day*	Missing	Always on same day	Sometimes on same day	Not on same day*	Missing		Always on same day	Sometimes on same day	Not on same day*	Missing	Always on same day	Sometimes on same day	Not on same day*	Missing	
Nairobi baseline																		
Public facility	63.4	4.9	31.7	0.0	90.2	2.4	7.3	0.0	41	63.4	4.9	31.7	0.0	90.2	2.4	7.3	0.0	41
Private facility	45.3	7.8	45.3	1.6	85.9	4.7	7.8	1.6	64	40.9	10.6	48.5	0.0	83.3	6.1	10.6	0.0	66
Nairobi endline																		
Public facility	84.6	7.7	7.7	0.0	98.1	1.9	0.0	0.0	52	76.9	11.5	11.5	0.0	90.4	3.8	5.8	0.0	52
Private facility	70.2	5.3	24.6	0.0	92.1	4.4	3.5	0.0	114	62.0	5.8	32.2	0.0	87.6	5.0	7.4	0.0	121
Mombasa baseline																		
Public facility	25.0	6.3	68.8	0.0	100.0	0.0	0.0	0.0	16	26.7	0.0	73.3	0.0	86.7	6.7	6.7	0.0	15
Private facility	45.2	7.1	45.2	2.4	95.2	0.0	4.8	0.0	42	40.9	11.4	47.7	0.0	81.8	0.0	18.2	0.0	44
Mombasa endline																		
Public facility	68.2	18.2	13.6	0.0	100.0	0.0	0.0	0.0	22	63.6	9.1	27.3	0.0	95.5	0.0	4.5	0.0	22
Private facility	67.3	9.1	23.6	0.0	94.5	1.8	3.6	0.0	55	64.9	8.8	26.3	0.0	94.7	1.8	3.5	0.0	57
Kisumu baseline																		
Public facility	27.8	0.0	72.2	0.0	94.4	5.6	0.0	0.0	18	27.8	0.0	72.2	0.0	88.9	11.1	0.0	0.0	18
Private facility	26.7	10.0	60.0	3.3	60.0	10.0	26.7	3.3	30	25.7	8.6	65.7	0.0	57.1	8.6	34.3	0.0	35
Kisumu endline																		
Public facility	55.6	5.6	38.9	0.0	100.0	0.0	0.0	0.0	18	38.9	16.7	44.4	0.0	100.0	0.0	0.0	0.0	18
Private facility	45.2	0.0	54.8	0.0	78.6	0.0	21.4	0.0	42	31.8	6.8	61.4	0.0	68.2	0.0	31.8	0.0	44
Machakos baseline																		
Public facility	25.0	0.0	75.0	0.0	100.0	0.0	0.0	0.0	4	20.0	0.0	80.0	0.0	80.0	0.0	20.0	0.0	5
Private facility	52.9	0.0	47.1	0.0	82.4	5.9	11.8	0.0	17	44.0	0.0	56.0	0.0	76.0	4.0	20.0	0.0	25
Machakos endline																		
Public facility	50.0	0.0	50.0	0.0	100.0	0.0	0.0	0.0	10	50.0	0.0	50.0	0.0	100.0	0.0	0.0	0.0	10
Private facility	52.2	4.3	43.5	0.0	91.3	0.0	8.7	0.0	23	50.0	4.2	45.8	0.0	87.5	0.0	12.5	0.0	24
Kakamega baseline																		
Public facility	28.6	28.6	42.9	0.0	85.7	14.3	0.0	0.0	7	25.0	25.0	50.0	0.0	75.0	12.5	12.5	0.0	8
Private facility	23.1	15.4	61.5	0.0	53.8	23.1	23.1	0.0	13	23.5	5.9	70.6	0.0	47.1	11.8	41.2	0.0	17
Kakamega endline																		
Public facility	85.7	0.0	14.3	0.0	85.7	14.3	0.0	0.0	7	62.5	25.0	12.5	0.0	62.5	25.0	12.5	0.0	8
Private facility	66.7	0.0	33.3	0.0	100.0	0.0	0.0	0.0	9	41.7	16.7	41.7	0.0	75.0	8.3	16.7	0.0	12

*No appointment made, always told to come back, given referral to another facility, given referral to another department, given no information or referral

Table 3.10: Providers' reports of provision of specific services at baseline and endline

Percentage of providers who offer a specific service and who say they routinely provide FP information to clients seeking that service, by city and managing authority, Kenya, 2011, 2014

City and managing authority	Antenatal care		Delivery care		Postnatal care		Postabortion care		Child health services		Curative services	
	Number of providers who offer antenatal care	Percentage who routinely provide FP info to antenatal care clients	Number of providers who offer delivery care	Percentage who routinely provide FP info to delivery care clients	Number of providers who offer postnatal care	Percentage who routinely provide FP info to postnatal care clients	Number of providers who offer postabortion care	Percentage who routinely provide FP info to postabortion care clients	Number of providers who offer child health services care	Percentage who routinely provide FP info to child health services clients	Number of providers who offer curative services	Percentage who routinely provide FP info to curative services clients
Nairobi baseline												
Public facility	131	91.6	40	97.5	113	100.0	40	100.0	130	94.6	115	69.6
Private facility	121	90.1	75	98.7	112	99.1	61	100.0	122	93.4	136	69.9
Nairobi endline												
Public facility	166	95.2	52	96.2	166	98.8	47	97.9	174	96.0	149	89.3
Private facility	208	88.0	115	95.7	199	95.5	112	97.3	195	88.7	220	75.9
Mombasa baseline												
Public facility	53	94.3	27	92.6	45	100.0	12	100.0	54	96.3	52	76.9
Private facility	68	85.3	47	85.1	58	98.3	45	95.6	63	88.9	68	63.2
Mombasa endline												
Public facility	67	85.1	44	100.0	62	100.0	29	100.0	65	98.5	67	85.1
Private facility	108	79.6	70	94.3	89	94.4	69	97.1	74	83.8	100	77.0
Kisumu baseline												
Public facility	44	95.5	17	100.0	42	100.0	12	100.0	44	100.0	44	93.2
Private facility	62	90.3	29	86.2	53	94.3	41	100.0	61	82.0	82	74.4
Kisumu endline												
Public facility	57	96.5	36	97.2	57	100.0	17	100.0	57	100.0	57	93.0
Private facility	74	87.8	25	96.0	66	90.9	44	88.6	66	93.9	107	66.4
Machakos baseline												
Public facility	10	100.0	2	100.0	8	100.0	3	100.0	9	88.9	14	78.6
Private facility	14	78.6	2	50.0	12	83.3	15	86.7	7	85.7	28	53.6
Machakos endline												
Public facility	23	95.7	12	100.0	19	100.0	11	90.9	23	100.0	22	86.4
Private facility	29	82.8	15	80.0	26	100.0	25	100.0	28	92.9	37	78.4
Kakamega baseline												
Public facility	20	90.0	4	75.0	15	100.0	8	100.0	19	100.0	23	78.3
Private facility	18	77.8	14	92.9	18	94.4	16	87.5	14	78.6	27	59.3
Kakamega endline												
Public facility	23	100.0	21	95.2	22	95.5	18	100.0	19	94.7	25	88.0
Private facility	21	90.5	11	100.0	17	94.1	15	93.3	9	77.8	22	72.7

FP information to clients coming for antenatal care, delivery care, postnatal care, postabortion care, child health services, or curative health services. Table 3.10 compares the percentage of health service providers who reportedly offer FP information to clients that sought other health services. Most of the providers, regardless of facility type and city, reported that they routinely offer FP information to clients seeking other services. On the other hand, clients reported a different story (Table 3.7). The percentage of exit interview clients who received any FP information while seeking other health services ranged from 10.4 percent during curative care to 54.5 percent during postabortion care visits.

By endline, more than 85 percent of providers in public facilities reported that they routinely offer FP information for clients who sought other health services. Even if the practice improved since baseline, providers in both public and private facilities were less likely to routinely offer FP information to clients seeking curative services than clients seeking other health services across all cities. The percentage of providers who routinely offer FP information to women in private facilities slightly declined in Nairobi since baseline; however, substantial improvements were seen in Machakos (Table 3.10).

FP Counseling

Improving the interactions between clients and providers improves the quality of care. In the presence of good client-provider interactions, clients can make well-informed choices, providers can address clients' concerns about side effects, satisfied users can return for supplies or follow-up; and providers can improve their counseling skills. Women who sought FP services were asked what topics the provider discussed on that day. Table 3.11 presents what happened during actual consultations among current users, new acceptors/dropout users, and current users who switched methods. Dropout clients refer to clients who used contraceptive methods at some point in time but had stopped using contraception by the time of the interview. Client-provider interactions improved in Machakos since baseline. The percentage of new acceptors and dropout clients users who received information about different methods increased from 42.2 to 67.3 percent in Nairobi, from 64.0 to 67.1 percent in Mombasa, and from 37.5 to 77.8 percent in Machakos. Current users who switched methods were more likely to report that providers asked about any other FP method they would prefer; however, this topic was discussed less frequently among current users. More than two-thirds of FP clients reported that they received information on when to return for follow-up at baseline and endline.

Service Providers' Training

In-Service Training

Providers' training is an important aspect of the delivery of quality services at health facilities. Such trainings can help to close gaps in knowledge and skills and, moreover, can change providers' attitudes toward FP. Service providers were asked a series of questions on in-service FP training, recency of training, and topics of training. At endline, the percentage of providers who ever received in-service training on FP increased in public facilities as compared to the baseline. Patterns of in-service training on FP in private facilities were similar at baseline and endline. At baseline, only Nairobi had over 50 percent of the providers trained on FP in public facilities; however, at the endline survey, Kisumu was the only city where FP training in public facilities did not achieve the 50 percent mark. At least half of the providers interviewed in Mombasa, Kisumu, and Machakos reported having received in-service training on FP one to three years before the endline survey (Figure 3.2).

In-service training covered general FP information and method-specific topics. By endline, the percentage of providers who had in-service training in general FP counseling skills showed an increase in Nairobi, Mombasa, and Machakos; for example, in Machakos, the percentage increased from 72.2 to 96.3 percent. In-service training on implants increased considerably from baseline to endline, from 44.4 to 96.3 percent in Machakos, from 75.6 to 91.8 percent in Nairobi, and from 69.1 to 85.2 percent in Mombasa. At endline, the percentage of providers who had received in-service training on injectables ranged from 73.7 percent in Kakamega to 96.3 percent in Machakos. Training on IUDs ranged from 80 percent in Kisumu to 96.3 percent in Machakos at endline, while female sterilization training ranged from 51.1 percent in Nairobi to 77.8 percent in Machakos.

Table 3.11: Clients' reports of selected aspects of FP services at baseline and endline

Percentage of FP exit clients at high volume/strategic sites reporting on selected aspects of quality FP services by city, Kenya, 2011, 2014

Clients' report	Nairobi		Mombasa		Kisumu		Machakos		Kakamega	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Current users										
Provider provided information about different FP methods	43.3	42.9	43.4	39.0	33.3	31.7	25.0	33.3	36.4	43.1
Provider asked about any other FP method client would prefer	54.2	51.9	46.5	40.1	38.1	43.6	35.3	34.8	34.5	63.3
Provider asked specifically about any problems client had with method used prior to visit	61.7	71.9	63.6	64.4	63.9	59.0	63.8	80.1	78.2	66.1
Provider suggested action(s) to resolve any problems	46.1	61.4	40.3	56.9	49.0	46.3	33.6	67.4	52.7	59.6
Provider talked about side effects of method client was using prior to visit	54.4	41.9	35.7	41.6	39.5	43.6	29.3	36.9	34.5	45.9
Provider told her when to return for follow-up	95.2	94.3	95.3	88.0	95.2	89.4	99.1	92.2	96.4	88.1
Total number of current users	**397**	**513**	**129**	**267**	**147**	**227**	**116**	**141**	**55**	**109**
New acceptors and drop-out users										
Provider provided information about different FP methods	44.2	67.3	64.0	67.1	48.4	40.5	37.5	77.8	75.0	38.9
Provider asked about client's method of choice	74.2	75.0	80.0	76.7	61.3	78.4	62.5	100.0	81.3	66.7
Provider helped client select a method	29.2	34.6	40.0	45.2	35.5	40.5	12.5	44.4	43.8	11.1
Provider explained how to use the method	65.0	57.7	52.0	69.9	35.5	56.8	37.5	44.4	62.5	38.9
Provider talked about possible side effects	69.2	53.8	36.0	71.2	35.5	32.4	37.5	55.6	62.5	38.9
Provider told client what to do if she had any problems	77.5	51.9	36.0	69.9	54.8	45.9	37.5	55.6	62.5	61.1
Provider told client when to return for follow-up	89.2	78.8	88.0	80.8	83.9	81.1	100.0	77.8	93.8	77.8
Total number of new acceptors and drop-out users	**120**	**52**	**25**	**73**	**31**	**37**	**8**	**9**	**16**	**18**
Current users who switched methods										
Provider provided information about different FP methods	76.1	68.8	77.8	63.9	68.8	77.4	36.4	90.9	76.9	77.8
Provider asked about any other FP method client would prefer	78.3	83.6	77.8	62.7	71.9	83.0	45.5	90.9	100.0	88.9
Provider asked specifically about any problems client had with method used prior to visit	72.8	68.8	51.9	56.6	43.8	67.9	36.4	70.5	61.5	55.6
Provider suggested action(s) to resolve any problems	65.2	56.3	37.0	45.8	31.3	56.6	27.3	54.5	53.8	77.8
Provider talked about side effects of method client was using prior to visit	72.8	55.5	29.6	50.6	46.9	50.9	45.5	75.0	38.5	88.9
Provider helped client select another method	57.6	51.6	29.6	54.2	43.8	47.2	54.5	93.2	69.2	88.9
Provider explained how to use the new method	78.3	73.4	59.3	62.7	62.5	75.5	63.6	93.2	84.6	88.9
Provider talked about possible side effects of new method	66.3	59.4	37.0	68.7	59.4	77.4	54.5	81.8	69.2	66.7
Provider told client what to do if she had any problems with new method	66.3	68.0	40.7	74.7	65.6	84.9	54.5	88.6	84.6	77.8
Provider told client when to return for follow-up	90.2	95.3	85.2	81.9	84.4	86.8	72.7	84.1	92.3	66.7
Total number of current users who switched methods	**92**	**128**	**27**	**83**	**32**	**53**	**11**	**44**	**13**	**9**

Table 3.12: Providers' reports of trainings at baseline and endline

Percentage of providers receiving FP training and characteristics of trainings, by city, Kenya, 2011, 2014

	Nairobi		Mombasa		Kisumu		Machakos		Kakamega	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Percentage of providers who ever had in-service training on FP										
Providers ever trained from public facilities	56.2	78.4	42.6	67.5	41.3	49.3	40	66.7	42.3	58.6
Total number of providers from public facilities	**146**	**185**	**61**	**83**	**46**	**67**	**15**	**27**	**26**	**29**
Providers ever trained from private facilities	52.2	53.8	54.2	54.7	36.1	29.8	52.6	46.3	44.8	39.3
Total number of providers from private facilities	**157**	**247**	**83**	**128**	**83**	**131**	**38**	**41**	**29**	**28**
Among all who had in-service FP training, percentage reporting recency of last FP training										
Within the last year	38.4	39.6	40.8	41.3	38.8	20.8	7.7	13.5	37.5	35.7
1–3 years ago	43.9	44.2	36.6	50.0	24.5	62.5	61.5	59.5	45.8	32.1
4+ years ago	14.0	14.7	16.9	8.7	30.6	16.7	26.9	21.6	16.7	32.1
Don't remember/missing	3.7	1.4	5.6	0.0	6.1	0.0	3.8	5.4	0.0	0.0
Total number of providers who ever had in-service FP training	**164**	**278**	**71**	**126**	**49**	**72**	**26**	**37**	**24**	**28**
Among those who had in-service FP training in last three years, percentage reporting various FP training topics covered in last three years*										
General FP counseling skills	84.4	88.4	85.5	86.1	90.3	88.3	72.2	96.3	85.0	84.2
Contraceptive technology update	85.2	89.3	74.5	84.3	61.3	78.3	66.7	100.0	75.0	84.2
Method specific: LAM	83.0	73.0	67.3	67.0	87.1	76.7	50.0	85.2	70.0	57.9
Method specific: natural methods**	65.2	69.5	70.9	77.4	77.4	65.0	55.6	92.6	65.0	63.2
Method specific: SDM/CycleBeads	NA	74.2	NA	77.4	NA	56.7	NA	88.9	NA	57.9
Method specific: pill	85.2	91.0	83.6	91.3	83.9	85.0	55.6	92.6	70.0	78.9
Method specific: EC	85.9	85.4	76.4	82.6	77.4	80.0	55.6	85.2	70.0	78.9
Method specific: IUD	74.8	90.1	76.4	81.7	83.9	80.0	50.0	96.3	70.0	94.7
Method specific: injectable	82.2	91.8	81.8	87.8	87.1	85.0	50.0	96.3	55.0	73.7
Method specific: implant	75.6	91.8	69.1	85.2	77.4	88.3	44.4	96.3	70.0	84.2
Method specific: female sterilization	48.1	51.1	36.4	51.3	58.1	65.0	33.3	77.8	45.0	52.6
Method specific: male sterilization	43.7	48.9	32.7	48.7	54.8	68.3	27.8	74.1	35.0	42.1
Total number of providers who had in-service FP training in last three years	**135**	**233**	**55**	**115**	**31**	**60**	**18**	**27**	**20**	**19**

*Last three years at baseline covers the time period from 2008 to 2011. Last three years at endline covers the time period from 2011 to 2014.

**At baseline, SDM/CycleBeads were included with natural FP methods. At endline, SDM/CycleBeads was asked about separately.
NA=No data available

Figure 3.2: Recency of last in-service FP training at baseline and endline among providers who ever received in-service FP training

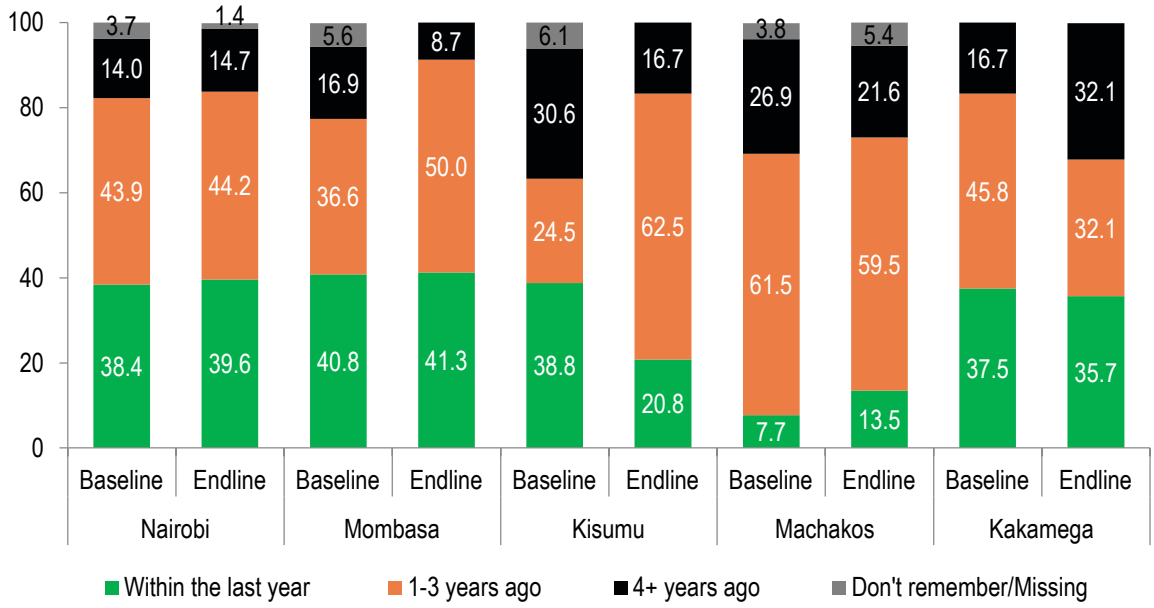


Table 3.12 compares the percentage of providers who have attended in-service trainings and the specific FP-related topics covered in the trainings at baseline and endline surveys.

Whole-Site Training

Facility managers were asked whether their facilities had participated in whole-site training and, if so, the organization that coordinated the trainings. Less than 50 percent of the facilities interviewed had ever participated in a whole-site training. Among facilities that reported receipt of whole site trainings, approximately 86 percent of whole site trainings were conducted by Tupange at Tupange-supported facilities whereas only about 30 percent of whole site trainings had been conducted by Tupange at non-Tupange facilities, as shown in Table 3.13. The matched facilities refer to those that had completed facility audits at both the baseline and endline time points.

Nearly one-third of the providers in all facilities reported that their facilities had participated in whole-site training, and four out of ten providers reported participation in mentorship programs on FP (Table 3.14). Providers in Tupange-supported facilities were much more likely to report participation in whole-site training and mentorship programs than those in non-Tupange facilities. Among providers who reported that their facilities participated in whole-site training, 84.8 percent either had attended or were currently attending the training; the corresponding percentage is higher among non-Tupange facilities than Tupange facilities. Tupange sponsored more than two-thirds of providers who participated in mentorship programs in Tupange-supported facilities and less than a quarter in non-Tupange facilities.

Provider Barriers

Providers were asked if they impose any restrictions on women who want to receive each FP method they provide based on parity, marital status, age, and another person's consent (Table 3.15). Private facility service providers were more likely to restrict women in need of the various FP methods for any reason; a higher percentage of private facility providers reported imposing restrictions based on age at endline than at baseline. Figure 3.3 shows restrictions on clients' eligibility to use FP methods based on minimum age at endline.

There was a general decrease in the percentage of providers who restrict access to methods at endline; however, female sterilization attracted more restrictions across all reasons when compared to baseline findings. By endline, more than 50 percent of providers in public and private facilities reported restricting clients' access to IUDs based on a minimum age, and a similar

Table 3.13: Exposure to whole-site training at endline

Percentage of facilities that report participation in whole-site training at endline according to Tupange support, Kenya, 2014

	All facilities	Tupange-supported (all facilities)	Non-Tupange-supported (all facilities)	Tupange-supported (matched)	Non-Tupange-supported (matched)
Percentage reporting participation in whole-site training	42.7	61.7	21.0	77.9	22.9
Total number of facilities	**377**	**201**	**176**	**113**	**144**
Among those who participated, percentage reporting organization that implemented whole-site training*					
Tupange	67.7	78.2	32.4	86.4	30.3
Tunza/PSI	6.2	1.6	21.6	2.3	24.2
MSI	8.7	7.3	13.5	3.4	15.2
IntraHealth	0.0	0.0	0.0	0.0	0.0
GIZ	0.0	0.0	0.0	0.0	0.0
AMUA-Tupange	5.6	7.3	0.0	4.5	0.0
AMUA	0.6	0.8	0.0	0.0	0.0
Total number of facilities	**161**	**124**	**37**	**88**	**33**

*Multiple responses possible

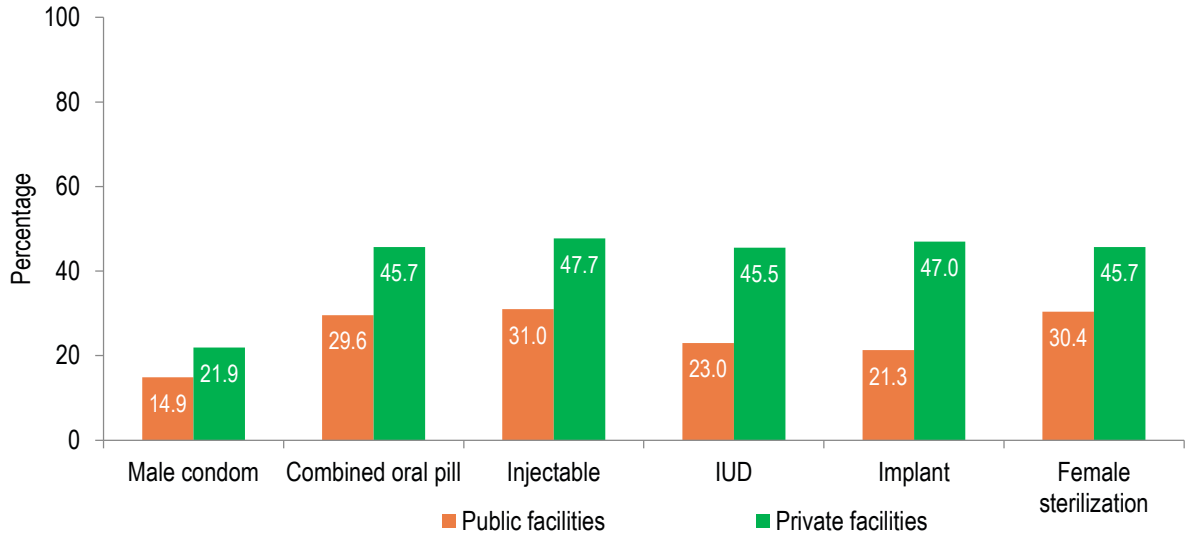
Table 3.14: Exposure to whole-site training at endline among providers surveyed

Percentage of providers who report participation in whole-site training at endline according to Tupange support, Kenya, 2014

	All facilities	Tupange-supported (all facilities)	Non-Tupange-supported (all facilities)	Tupange-supported (matched)	Non-Tupange-supported (matched)
Percentage of providers who report facility participated in whole-site training	31.5	48.2	9.4	54.1	10.4
Percentage of providers who participated in mentorship program on FP	39.9	48.9	27.9	52.1	31.0
Total number of providers	**966**	**550**	**416**	**355**	**336**
Among providers who reported facility participated in whole site training, percentage who report					
Attended and got certificate	34.2	32.8	43.6	34.4	40.0
Attended but did not get certificate	48.0	49.4	38.5	47.9	40.0
Attending now	2.6	1.1	12.8	1.6	14.3
Did not attend	14.5	15.8	5.1	15.1	5.7
Missing	0.7	0.8	0.0	1.0	0.0
Total number of providers who reported facility participated in whole-site training	**304**	**265**	**39**	**192**	**35**
Among providers who participated in mentorship program, percentage sponsored by*					
Tupange	58.2	75.1	19.0	77.3	19.2
Other organization	45.7	29.0	84.5	27.6	82.7
Total number of providers who participated in mentorship program	**385**	**269**	**116**	**185**	**104**

*More than one organization could be named

Figure 3.3: Provider restrictions on clients' eligibility to use FP methods based on minimum age at endline



percentage restricted use of the combined pill based on a maximum age. Other than a minimum age, providers were less likely to impose restrictions when issuing male condoms. Restrictions based on women's marital status at endline ranged from 0.5 percent for condom provision to 32.8 percent for female sterilization, whereas restrictions based on consent from another person ranged from 0.8 percent for condom provision to 68.9 percent for female sterilization.

Methods Offered

The availability of FP methods varied by facility type and city, though there are some shared trends (Table 3.16). Overall, a higher percentage of public facilities than private facilities provided various FP methods at endline. Provision of long-acting and permanent methods (LAPM, consisting of IUD, implant, female sterilization, or male sterilization) increased in both public and private facilities at endline, but the increase was considerable in public facilities; for instance, in Mombasa, provision increased from 50 to 100 percent, and in Machakos, from 60 to 100 percent. It should be noted that in some cities there were a small number of facilities. By endline, injectables, pills, emergency contraceptives, and male condoms were provided in most of the public health facilities, ranging from 72.2 percent in Kisumu to 100 percent in the majority of cities. Provision of male sterilization was at or below 20 percent in both public and private facilities in all cities at both baseline and endline. There was a general drop in the provision of FP methods by private facilities in Kisumu from baseline to endline.

Expanding the contraceptive mix is a key element to ensure access to and availability of method choice for women. On average, more than 80 percent of public facilities offered seven or more modern methods of FP at endline, as compared to 50 percent of private facilities, though there was variation by city. Mombasa had the most notable increase in the number of methods provided. Except for private health facilities in Kisumu, provision of modern methods increased irrespective of city and facility type since baseline. By endline, almost all public facilities in Mombasa and Nairobi provided seven or more modern FP methods. Most of the private facilities in Nairobi (72.9 percent) and Mombasa (75.4 percent) provided seven or more methods, but less than half provided seven or more methods in Machakos (42.3 percent), Kakamega (37.5 percent), and Kisumu (21.3 percent) by endline. Table 3.17 presents the details on the distribution percentages of facilities by number of modern methods offered at baseline and endline.

Stocks, Stock-Outs, and Redistribution

Facilities were audited on the availability of FP methods and stock-outs of methods for 30 days and one year prior to the survey. In this study, a stock-out is defined as a lack of availability of a method at a facility for 24 hours or longer, according to observation and

Table 3.15: Restrictions on clients' eligibility to use methods at baseline and endline

Among FP providers who reported that they know specific FP methods well enough to counsel and provide the method, percentage who restricted clients' eligibility to use a method by type of restriction and managing authority, Kenya, 2011, 2014

Restriction	Male condom	Com-bined oral pill	Injectable	IUD	Implant	Female steriliza-tion
BASELINE						
Percentage who restrict based on woman's parity						
Public	0.0	9.5	20.8	7.9	8.5	33.9
Private	0.3	14.3	30.4	25.1	23.5	53.3
Percentage who restrict based on woman's marital status						
Public	0.7	3.6	5.8	3.9	4.9	19.6
Private	0.5	7.8	12.9	11.7	12.2	39.1
Percentage who restrict based on other's consent						
Public	2.4	5.8	6.2	8.4	3.0	37.5
Private	3.5	11.0	12.3	19.9	21.3	58.7
Percentage who restrict based on a minimum age requirement*						
Public	14.9	29.6	31.0	23.0	21.3	30.4
Private	21.9	45.7	47.7	45.5	47.0	45.7
Percentage who report a maximum age to which they provide method**						
Public	3.8	27.7	28.8	15.7	23.8	1.8
Private	6.1	49.0	43.9	34.6	39.1	21.7
Total number of providers who know method well enough to provide and counsel the method						
Public	**289**	**274**	**274**	**178**	**164**	**56**
Private	**374**	**335**	**342**	**231**	**230**	**92**
ENDLINE						
Percentage who restrict based on woman's parity						
Public	0.3	2.8	8.6	8.9	7.6	69.6
Private	0.7	5.4	9.8	11.0	8.7	60.7
Percentage who restrict based on woman's marital status						
Public	0.5	1.1	2.8	7.7	7.3	21.7
Private	1.1	3.6	5.6	8.5	8.3	32.8
Percentage who restrict based on other's consent						
Public	0.8	5.3	5.0	9.3	8.3	65.2
Private	1.8	5.4	6.6	11.8	9.9	68.9
Percentage who restrict based on a minimum age requirement*						
Public	19.0	37.5	38.4	52.5	44.3	69.6
Private	29.0	51.7	56.6	67.9	63.4	73.8
Percentage who report a maximum age to which they provide method**						
Public	4.4	52.2	44.0	41.3	41.7	21.7
Private	5.9	66.5	63.5	58.5	60.6	41.0
Total number of providers who know method well enough to provide and counsel the method						
Public	**384**	**360**	**359**	**259**	**314**	**23**
Private	**544**	**501**	**502**	**390**	**424**	**61**

*Minimum age requirement defined as requiring that the woman be older than 15 years of age to receive the method.

**Maximum age was defined as not providing the method to a woman aged 49 or younger.

Table 3.16: Provision of FP methods at baseline and endline

Percentage of public and private health facilities providing FP methods by city and managing authority, Kenya, 2011, 2014

	Nairobi		Mombasa		Kisumu		Machakos		Kakamega	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Public facilities										
IUD	80.5	98.1	50.0	95.5	27.8	72.2	40.0	50.0	50.0	87.5
Implant	73.2	100.0	50.0	100.0	33.3	100.0	60.0	100.0	37.5	87.5
Injectables	100.0	100.0	100.0	100.0	100.0	94.4	80.0	100.0	87.5	87.5
Combined oral pills	100.0	100.0	100.0	100.0	100.0	100.0	80.0	100.0	87.5	87.5
Progestin-only pills	100.0	100.0	100.0	100.0	100.0	100.0	80.0	100.0	87.5	87.5
Emergency contraceptives	97.6	98.1	100.0	95.5	100.0	72.2	80.0	90.0	87.5	87.5
Male condom	97.6	100.0	100.0	100.0	100.0	100.0	80.0	100.0	100.0	87.5
Female condom	82.9	98.1	75.0	100.0	44.4	44.4	20.0	70.0	25.0	87.5
Female sterilization	31.7	38.5	31.3	9.1	16.7	5.6	40.0	10.0	12.5	12.5
Male sterilization	7.3	19.2	18.8	9.1	11.1	11.1	20.0	20.0	12.5	12.5
Standard Days Method	NA	50.0	NA	77.3	NA	16.7	NA	80.0	NA	62.5
Breastfeeding/LAM	NA	63.5	NA	86.4	NA	44.4	NA	70.0	NA	75.0
Any LAPM*	82.9	100.0	50.0	100.0	33.3	100.0	60.0	100.0	50.0	87.5
Number of public facilities	**41**	**52**	**16**	**22**	**18**	**18**	**5**	**10**	**8**	**8**
Private facilities										
IUD	64.7	76.0	54.5	77.2	47.2	44.7	52.0	53.8	38.9	56.3
Implant	66.2	84.3	56.8	82.5	38.9	55.3	56.0	61.5	27.8	56.3
Injectables	94.1	95.9	97.7	98.2	75.0	72.3	84.0	84.6	66.7	75.0
Combined oral pills	94.1	95.9	95.5	89.5	75.0	61.7	80.0	73.1	61.1	68.8
Progestin-only pills	88.2	89.3	88.6	86.0	63.9	38.3	56.0	53.8	33.3	62.5
Emergency contraceptives	83.8	80.2	88.6	73.7	55.6	27.7	52.0	57.7	38.9	62.5
Male condom	92.6	93.4	88.6	89.5	72.2	63.8	64.0	69.2	55.6	50.0
Female condom	51.5	64.5	52.3	59.6	33.3	17.0	24.0	26.9	11.1	25.0
Female sterilization	11.8	11.6	11.4	10.5	22.2	4.3	16.0	23.1	16.7	6.3
Male sterilization	5.9	5.8	11.4	10.5	16.7	8.5	8.0	19.2	16.7	6.3
Standard Days Method	NA	28.1	NA	42.1	NA	0.0	NA	30.8	NA	6.3
Breastfeeding/LAM	NA	50.4	NA	59.6	NA	23.4	NA	46.2	NA	18.8
Any LAPM*	73.5	86.0	61.4	84.2	58.3	57.4	56.0	61.5	38.9	56.3
Number of private facilities	**68**	**121**	**44**	**57**	**36**	**47**	**25**	**26**	**18**	**16**

*LAPM = IUD, implant, female sterilization, male sterilization
NA=No data available

Table 3.17: Provision of modern methods at baseline and endline

Distribution percentages of facilities providing modern methods by number of methods provided according to city and managing authority, Kenya, 2011, 2014*

	Number of modern methods provided									
	No methods		1-3 methods		4-6 methods		7+ methods		Number of facilities	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	**Baseline**	**Endline**
Nairobi										
Public facility	0.0	0.0	0.0	0.0	17.1	1.9	82.9	98.1	**41**	**52**
Private facility	5.9	4.1	1.5	2.5	35.3	21.5	57.4	71.9	**68**	**121**
Mombasa										
Public facility	0.0	0.0	0.0	0.0	50.0	0.0	50.0	100.0	**16**	**22**
Private facility	2.3	1.8	2.3	10.5	38.6	12.3	56.8	75.4	**44**	**57**
Kisumu										
Public facility	0.0	0.0	0.0	0.0	66.7	38.9	33.3	61.1	**18**	**18**
Private facility	16.7	25.5	8.3	12.8	41.7	40.4	33.3	21.3	**36**	**47**
Machakos										
Public facility	20.0	0.0	0.0	0.0	40.0	30.0	40.0	70.0	**5**	**10**
Private facility	4.0	11.5	32.0	15.4	32.0	30.8	32.0	42.3	**25**	**26**
Kakamega										
Public facility	0.0	12.5	12.5	0.0	50.0	0.0	37.5	87.5	**8**	**8**
Private facility	33.3	25.0	11.1	12.5	27.8	25.0	27.8	37.5	**18**	**16**

*Modern methods include male and female sterilization, implant, combined oral pill, IUD, injectables, condoms, emergency contraception.

records. Table 3.18 presents current availability and stock-out of FP methods in the last 30 days and last year by method, facility type, and city. In Nairobi and Kakamega, irrespective of facility type, the percentage of facilities that had IUDs, implants, and injectables in stock increased or stayed the same since baseline. For example, in Kakamega, the percentage of public facilities with implants in stock drastically increased from 33.3 percent to 100 percent at endline. No data were collected on the Standard Days Method (SDM) at baseline; however, at endline, except for private facilities in Kisumu, it was offered by more than two-thirds of both public and private facilities. In general, the stock of emergency contraceptives was lower at endline than at baseline. Differences between cities should be interpreted with caution given the small number of facilities in Kakamega and Machakos that offer each method.

Overall, all health facilities were less likely to report stock-outs at endline than at baseline. Nevertheless, in the 30 days prior to the survey, most public facilities were more likely to experience stock-outs of emergency contraceptives, progestin-only pills, female condoms, and SDM than of other methods at endline. In private facilities, on the other hand, stock-outs were evenly distributed across methods and cities. One month prior to the endline survey, up to 10 percent of public facilities experienced stock-outs of long-acting methods—IUDs and implants—whereas stock-outs in the previous 30 days were up to 16 percent in private facilities. In the last 30 days prior to the endline survey, more than three-fourths of public facilities and more than half of the private facilities experienced a stock-out of progestin-only pills in Nairobi. For the same period, more than half experienced stock-out of emergency contraceptives in both public and private facilities in Kakamega.

Stock-outs in both public and private facilities had similar patterns at 30 days prior to the survey and one year prior to survey. For the previous one-year period, the percentages were higher across cities and methods.

Table 3.18: Facilities that had stock-outs of FP methods at baseline and endline

Percentage of health facilities that had a stock-out of FP method in the previous 30 days and previous year by city and managing authority, Kenya, 2011, 2014

	Public facilities								Private facilities							
	Number of facilities providing method		Percentage of facilities that have method currently in stock		Percentage of facilities with a stock-out in the previous 30 days		Percentage of facilities with a stock-out in the previous year		Number of facilities providing method		Percentage of facilities that have method currently in stock		Percentage of facilities with a stock-out in the previous 30 days		Percentage of facilities with a stock-out in the previous year	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Nairobi																
IUD	33	51	84.8	88.2	15.2	3.9	21.2	3.9	44	92	84.1	89.1	15.9	7.6	25.0	10.9
Implant	30	52	80.0	94.2	16.7	3.8	43.3	15.4	45	102	84.4	96.1	15.6	5.9	31.1	15.7
Injectables	41	52	82.9	96.2	29.3	3.8	68.3	11.5	64	116	87.5	97.4	17.2	5.2	57.8	16.4
Combined oral pill	41	52	80.5	96.2	19.5	3.8	41.5	7.7	64	116	87.5	87.9	18.8	12.9	43.8	21.6
Progestin-only pill	41	52	95.1	26.9	4.9	80.8	29.3	86.5	60	108	95.0	35.2	6.7	66.7	21.7	76.9
Emergency contraceptives	40	51	92.5	70.6	10.0	31.4	12.5	37.3	57	97	93.0	69.1	14.0	37.1	42.1	45.4
Male condom	40	52	97.5	96.2	7.5	5.8	52.5	17.3	63	113	93.7	88.5	9.5	12.4	46.0	16.8
Female condom	34	51	67.6	72.5	41.2	27.5	61.8	43.1	35	78	80.0	75.6	28.6	26.9	45.7	37.2
Standard Days Method	NA	26	NA	92.3	NA	7.7	NA	26.9	NA	34	NA	82.4	NA	17.6	NA	20.6
Mombasa																
IUD	8	21	62.5	95.2	25.0	4.8	25.0	9.5	24	44	91.7	84.1	8.3	15.9	29.2	20.5
Implant	8	22	62.5	100.0	37.5	4.5	50.0	4.5	25	47	88.0	93.6	16.0	6.4	28.0	12.8
Injectables	16	22	87.5	86.4	31.3	18.2	62.5	27.3	43	56	93.0	96.4	20.9	7.1	51.2	17.9
Combined oral pill	16	22	100.0	77.3	6.3	22.7	25.0	27.3	42	51	95.2	96.1	16.7	9.8	33.3	31.4
Progestin-only pill	16	22	87.5	90.9	25.0	18.2	50.0	45.5	39	49	84.6	73.5	25.6	28.6	38.5	49.0
Emergency contraceptives	16	21	81.3	85.7	31.3	14.3	31.3	23.8	39	42	64.1	54.8	35.9	47.6	48.7	59.5
Male condom	16	22	87.5	100.0	18.8	0.0	37.5	0.0	39	51	84.6	94.1	20.5	5.9	43.6	15.7
Female condom	12	22	83.3	81.8	25.0	18.2	33.3	40.9	23	34	87.0	76.5	30.4	26.5	39.1	38.2
Standard Days Method	NA	17	NA	94.1	NA	5.9	NA	11.8	NA	24	NA	95.8	NA	4.2	NA	16.7
Kisumu																
IUD	5	13	100.0	92.3	0.0	0.0	20.0	0.0	17	21	88.2	95.2	0.0	0.0	5.9	4.8
Implant	6	18	100.0	100.0	0.0	0.0	16.7	11.1	14	26	100.0	96.2	7.1	3.8	21.4	15.4
Injectables	18	17	83.3	100.0	22.2	0.0	38.9	5.9	27	34	88.9	100.0	25.9	0.0	48.1	2.9

NA = No data available

Table Continued

3.18 Table Continued

	Public facilities								Private facilities							
	Number of facilities providing method		Percentage of facilities that have method currently in stock		Percentage of facilities with a stock-out in the previous 30 days		Percentage of facilities with a stock-out in the previous year		Number of facilities providing method		Percentage of facilities that have method currently in stock		Percentage of facilities with a stock-out in the previous 30 days		Percentage of facilities with a stock-out in the previous year	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Combined oral pill	18	18	100.0	94.4	0.0	5.6	5.6	5.6	27	29	88.9	93.1	14.8	13.8	29.6	20.7
Progestin-only pill	18	18	100.0	94.4	0.0	33.3	5.6	44.4	23	18	82.6	88.9	26.1	16.7	47.8	27.8
Emergency contraceptives	18	13	94.4	92.3	5.6	46.2	11.1	61.5	20	13	85.0	84.6	25.0	30.8	40.0	46.2
Male condom	18	18	77.8	100.0	27.8	5.6	61.1	27.8	26	30	92.3	100.0	23.1	10.0	53.8	13.3
Female condom	8	8	75.0	87.5	25.0	50.0	50.0	62.5	12	8	83.3	87.5	33.3	25.0	41.7	50.0
Standard Days Method	NA	3	NA	66.7	NA	33.3	NA	33.3	NA	0	NA	0.0	NA	0.0	NA	0.0
Machakos																
IUD	2	5	50.0	80.0	0.0	0.0	0.0	0.0	13	14	84.6	92.9	15.4	7.1	38.5	14.3
Implant	3	10	100.0	90.0	33.3	10.0	66.7	10.0	14	16	71.4	100.0	35.7	6.3	57.1	12.5
Injectables	4	10	100.0	100.0	0.0	10.0	25.0	10.0	21	22	85.7	95.5	23.8	4.5	33.3	9.1
Combined oral pill	4	10	100.0	100.0	0.0	0.0	0.0	0.0	20	19	85.0	100.0	20.0	5.3	30.0	26.3
Progestin-only pill	4	10	75.0	60.0	25.0	40.0	25.0	50.0	14	14	78.6	78.6	21.4	21.4	50.0	21.4
Emergency contraceptives	4	9	100.0	55.6	25.0	44.4	25.0	44.4	13	15	76.9	80.0	30.8	26.7	30.8	60.0
Male condom	4	10	100.0	80.0	0.0	20.0	25.0	30.0	16	18	62.5	77.8	37.5	22.2	50.0	27.8
Female condom	1	7	100.0	85.7	0.0	14.3	0.0	14.3	6	7	66.7	71.4	50.0	42.9	66.7	57.1
Standard Days Method	NA	8	NA	87.5	NA	25.0	NA	25.0	NA	8	NA	75.0	NA	37.5	NA	37.5
Kakamega																
IUD	4	7	100.0	100.0	0.0	0.0	0.0	14.3	7	9	100.0	100.0	0.0	0.0	28.6	0.0
Implant	3	7	33.3	100.0	66.7	0.0	66.7	28.6	5	9	100.0	100.0	0.0	0.0	0.0	0.0
Injectables	7	7	100.0	100.0	0.0	0.0	85.7	0.0	12	12	83.3	100.0	16.7	0.0	41.7	0.0
Combined oral pill	7	7	100.0	100.0	0.0	0.0	0.0	0.0	11	11	100.0	81.8	0.0	18.2	36.4	18.2
Progestin-only pill	7	7	100.0	100.0	0.0	0.0	0.0	14.3	6	10	100.0	70.0	0.0	30.0	16.7	30.0
Emergency contraceptives	7	7	100.0	85.7	0.0	57.1	0.0	85.7	7	10	71.4	50.0	28.6	60.0	42.9	80.0
Male condom	8	7	100.0	100.0	12.5	0.0	37.5	0.0	10	8	70.0	100.0	30.0	0.0	30.0	0.0
Female condom	2	7	100.0	100.0	0.0	0.0	50.0	57.1	2	4	50.0	75.0	50.0	50.0	50.0	50.0
Standard Days Method	NA	5	NA	80.0	NA	20.0	NA	40.0	NA	1	NA	100.0	NA	0.0	NA	0.0

NA = No data available

Figure 3.4 presents public facilities that had stock-outs of FP methods in Nairobi, Mombasa, and Kisumu within one year prior to the endline survey.

Emergency distribution of FP methods from one facility to another is a useful tool for ensuring method availability when there is a shortage of specific commodities. Overall, a higher percentage of facilities in Nairobi received an emergency distribution of FP methods than did facilities in the other cities in the three months prior to the survey; additionally, they participated in redistributing FP methods more than any other city. Nairobi was the only city whose public facilities received emergency distribution of all FP methods. On the other hand, facilities in Kisumu benefited least from the emergency redistribution; only IUDs and emergency contraceptives were distributed to the public facilities and male condoms to the private facilities. SDM was the least-reported method in the emergency distribution across cities; private facilities (12.5 percent) in Machakos and public facilities (3.8 percent) in Nairobi received SDM in the three-month period prior to the survey. A higher percentage of public facilities than private facilities participated in the emergency redistribution of FP methods, especially in Kakamega, where there was a substantial difference between the two facility types. Table 3.19 shows distribution and redistribution patterns for public and private facilities across the cities.

Client Exposure to FP Messages and Tupange Program

Exit interview clients were asked if they had heard or seen the name "Tupange" or had ever seen Tupange's logo. Tupange is a Kiswahili word meaning "let's plan" or "we plan together." Table 3.20 presents exposure of exit interview clients to the Tupange logo at endline.

About three quarters of clients across cities reported that they had heard or seen the word "Tupange" in the year prior to the exit interview survey. Women who reported having ever seen the Tupange program logo ranged from 62.5 percent in Machakos to 76.3 percent in Nairobi (Figure 3.5). Women who have ever seen the logo were asked where they had seen it; the most frequent answers were television, posters, health worker uniforms, and signs at health facilities.

Approximately one-third of exit interview clients reported having read any newspapers or magazines in the previous year. Among those, two-thirds or more reported having read about FP and childbirth spacing.

Figure 3.4: Public facilities that had stock-outs of FP methods in the last one year in selected cities at endline

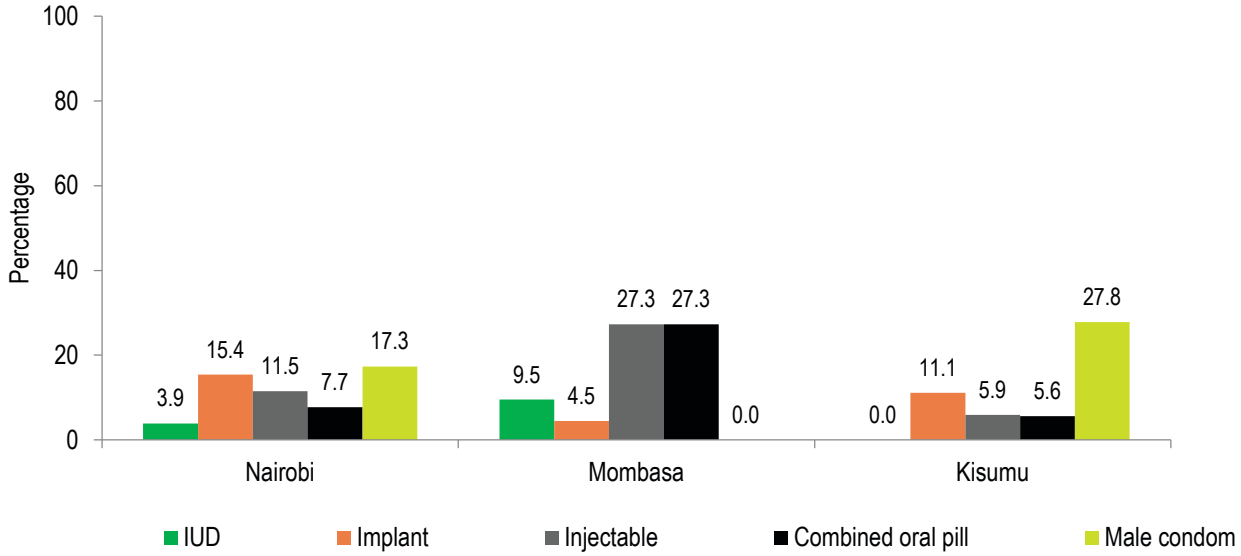


Table 3.19: Facilities that reported emergency distribution or redistribution of contraceptives at endline

Among facilities providing various FP methods, percentage that had received emergency distribution or participated in redistribution of contraceptives, by city and managing authority, Kenya, 2014

	Public facilities			Private facilities		
	Number of facilities providing the method	Percentage of facilities that received an emergency distribution of the method in the previous three months	Percentage of facilities that have ever participated in redistribution of method to another facility or received method from another facility	Number of facilities providing the method	Percentage of facilities that received an emergency distribution of the method in the previous three months	Percentage of facilities that have ever participated in redistribution of method to another facility or received method from another facility
Nairobi						
IUD	51	5.9	45.1	92	4.3	30.4
Implant	52	9.6	53.8	102	3.9	34.3
Injectables	52	3.8	50.0	116	3.4	26.7
Combined oral pill	52	1.9	65.4	116	3.4	34.5
Progestin-only pill	52	9.6	44.2	108	6.5	27.8
Emergency contraceptives	51	7.8	39.2	97	4.1	26.8
Male condom	52	9.6	65.4	113	7.1	32.7
Female condom	51	5.9	43.1	78	6.4	35.9
Standard Days Method	26	3.8	26.9	34	0.0	38.2
Mombasa						
IUD	21	0.0	14.3	44	2.3	15.9
Implant	22	0.0	45.5	47	6.4	23.4
Injectables	22	0.0	36.4	56	7.1	23.2
Combined oral pill	22	4.5	40.9	51	3.9	27.5
Progestin-only pill	22	0.0	18.2	49	2.0	12.2
Emergency contraceptives	21	0.0	14.3	42	7.1	4.8
Male condom	22	0.0	18.2	51	5.9	17.6
Female condom	22	0.0	13.6	34	8.8	20.6
Standard Days Method	17	0.0	0.0	24	0.0	0.0
Kisumu						
IUD	13	7.7	7.7	21	0.0	9.5
Implant	18	0.0	11.1	26	0.0	19.2
Injectables	17	0.0	5.9	34	0.0	11.8
Combined oral pill	18	0.0	22.2	29	0.0	17.2
Progestin-only pill	18	0.0	11.1	18	0.0	16.7
Emergency contraceptives	13	7.7	15.4	13	0.0	7.7
Male condom	18	0.0	16.7	30	3.3	10.0
Female condom	8	0.0	0.0	8	0.0	25.0
Standard Days Method	3	0.0	0.0	0	0.0	0.0

Table Continued

Table 3.19 Continued

	Public facilities			Private facilities		
	Number of facilities providing the method	Percentage of facilities that received an emergency distribution of the method in the previous three months	Percentage of facilities that have ever participated in redistribution of method to another facility or received method from another facility	Number of facilities providing the method	Percentage of facilities that received an emergency distribution of the method in the previous three months	Percentage of facilities that have ever participated in redistribution of method to another facility or received method from another facility
Machakos						
IUD	5	0.0	40.0	14	0.0	50.0
Implant	10	0.0	20.0	16	12.5	37.5
Injectables	10	10.0	20.0	22	13.6	31.8
Combined oral pill	10	10.0	40.0	19	5.3	36.8
Progestin-only pill	10	0.0	40.0	14	0.0	35.7
Emergency contraceptives	9	11.1	22.2	15	13.3	33.3
Male condom	10	20.0	30.0	18	5.6	27.8
Female condom	7	0.0	0.0	7	0.0	71.4
Standard Days Method	8	0.0	0.0	8	12.5	25.0
Kakamega						
IUD	7	0.0	57.1	9	0.0	0.0
Implant	7	0.0	71.4	9	0.0	11.1
Injectables	7	0.0	42.9	12	0.0	8.3
Combined oral pill	7	0.0	71.4	11	0.0	9.1
Progestin-only pill	7	0.0	57.1	10	10.0	10.0
Emergency contraceptives	7	28.6	42.9	10	10.0	10.0
Male condom	7	14.3	71.4	8	0.0	12.5
Female condom	7	14.3	42.9	4	0.0	0.0
Standard Days Method	5	0.0	20.0	1	0.0	0.0

Table 3.20: Exit interview clients reporting exposure to Tupange logo at endline

Percentage distribution of exit interview clients at high volume/strategic sites by exposure to the Tupange logo, according to city, Kenya, 2014

	Nairobi	Mombasa	Kisumu	Machakos	Kakamega
Heard or seen the word "Tupange" in the past year					
Yes	77.4	79.4	78.9	68.4	70.7
No	22.6	20.7	21.1	31.6	29.3
Number of exit interview clients	**1602**	**1162**	**1158**	**522**	**417**
Ever seen "Tupange" program logo					
Yes	76.3	76.0	72.6	62.5	69.5
No	23.7	24.0	27.4	37.6	30.5
Number of exit interview clients	**1602**	**1162**	**1158**	**522**	**417**
Among those who saw the logo, where it was seen					
Television	30.7	40.9	22.8	26.4	27.9
Poster	38.5	18.7	34.1	52.2	31.7
News magazine or booklet	0.8	1.4	0.8	2.8	1.4
Leaflet/fliers	0.8	2.5	11.5	12.3	5.9
T-shirt	3.3	4.3	6.0	7.4	7.6
Health worker uniform/coat	23.8	10.9	19.1	28.2	9.7
Sign at a health facility	15.9	47.0	23.3	21.5	25.5
Street banner	1.1	1.8	3.0	0.9	0.3
Khanga/leso	0.5	0.1	1.3	2.5	1.4
Other	0.6	1.7	3.0	2.5	4.1
Can't remember	4.3	3.3	2.6	3.1	3.5
Missing	0.2	0.2	0.1	0.3	0.0
Number of exit interview clients who had seen the "Tupange" logo	**1223**	**883**	**841**	**326**	**290**

In contrast, only about one-third of women exposed to newspapers and magazines reported having read articles related to the Tupange project. Over 50 percent of women across all cities had read or seen the "celebrate life" posters in the year prior to the survey. A majority of the clients had not seen or read "Tupange Imarisha Maisha" brochures. More than a quarter of the women had seen or read the comic book *Shujaaz*; of these, women who had seen or read issues of *Shujaaz* that covered "relationships, teenage pregnancy or male responsibility" ranged from 57.5 percent in Kisumu to 75.5 percent in Machakos. Table 3.21 shows details on clients' exposure to Tupange print materials.

Radio listenership and television viewership are high across cities; between 85 and 98 percent of clients listened to radio at least occasionally, and between 81 and 92 percent had watched TV at least occasionally in the previous three months (Table 3.22). Of those who listened to the radio, a large percentage of women (ranging from 86 percent in Mombasa to 95 percent in Machakos and Kakamega) reported hearing about childbirth spacing or FP on the radio in the previous year. Across cities, the *Jongo Love* radio program was listened to by less than a quarter of the clients who had listened to the radio three months prior to the survey. Among women who watched television in the previous three months, most of them (ranging from 89 percent in Mombasa to 95 percent in Kakamega) saw child birth spacing or FP information on television in the previous year.

Internet use varies slightly across cities. Access to the internet one year prior to the survey ranged from 19.4 percent in Mombasa to 46.3 percent in Kakamega. Among women who accessed the internet, nearly half reported daily usage. Tupange used various internet resources to generate demand for FP. Facebook, followed by YouTube, was reported most frequently across cities as an information source for messages about teenage pregnancy, relationships, or male responsibility among those women who reported having accessed the internet (Table 3.23).

Exit interview clients were asked if they had heard any information about teenage pregnancy, relationships, male responsibility, or FP at various Tupange events (Table 3.24). Across cities, more than half of the clients

Figure 3.5: Exit interview clients reporting exposure to Tupange logo at endline

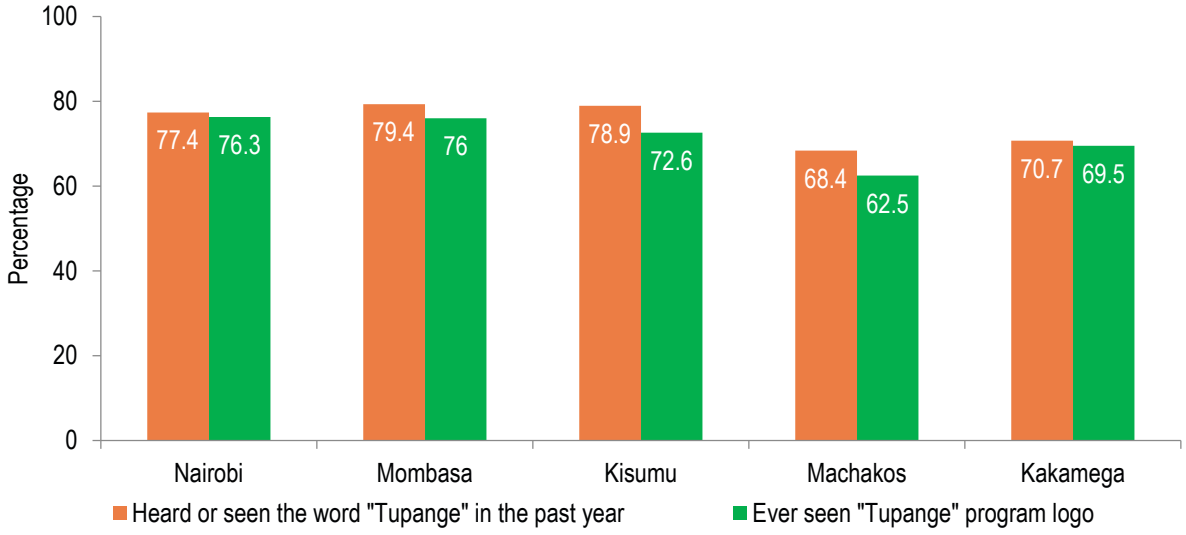


Table 3.21: Exit interview clients' exposure to Tupange printed materials at endline

Percentage distribution of exit interview clients at high volume/strategic sites by exposure to Tupange printed materials, by city, Kenya, 2014

	Nairobi	Mombasa	Kisumu	Machakos	Kakamega
Percentage who had read any newspaper(s) or magazines in the previous year					
Yes	36.4	32.3	37.5	52.9	59.5
No	63.6	67.7	62.5	47.1	40.5
Missing	0.1	0.0	0.0	0.0	0.0
Number of exit interview clients	**1602**	**1162**	**1158**	**522**	**417**
Among those who had read a newspaper/magazine within the previous year, percentage who had read any articles on FP/child birth spacing in those media during that period					
Yes	73.6	66.7	75.6	81.2	73.0
No	25.7	31.5	22.8	18.8	26.6
Don't know	0.7	1.9	1.6	0.0	0.4
Number of exit interview clients who read newspaper/magazine in the past year	**583**	**375**	**434**	**276**	**248**
Among those who had read a newspaper/magazine within the previous year, percentage who had read any articles on FP in those media that talked about the Tupange project during that period					
Yes	32.9	44.8	31.8	26.8	28.6
No	65.2	52.5	65.7	69.9	69.8
Don't know	1.9	2.7	2.5	3.3	1.6
Number of exit interview clients who read newspaper/magazine in the past year	**583**	**375**	**434**	**276**	**248**
Percentage who had seen or read a brochure/leaflet on FP with the text "Tupange Imarisha Maisha" in the previous year					
Yes	48.7	43.4	58.6	39.7	54.9
No	51.3	56.6	41.5	60.3	45.1
Missing	0.1	0.0	0.0	0.0	0.0
Number of exit interview clients	**1602**	**1162**	**1158**	**522**	**417**
Percentage who had seen or read a poster with Tupange or the text "Celebrate Life! Use Family Planning" in the previous year					
Yes	57.0	57.8	65.4	59.6	54.9
No	43.0	42.2	34.6	40.4	45.1
Missing	0.0	0.1	0.0	0.0	0.0
Number of exit interview clients	**1602**	**1162**	**1158**	**522**	**417**
Percentage who had seen or heard of the *Shujaaz* comic book					
Yes	30.2	27.9	25.8	28.2	32.6
No	69.7	72.1	74.2	71.8	67.4
Missing	0.1	0.0	0.0	0.0	0.0
Number of exit interview clients	**1602**	**1162**	**1158**	**522**	**417**
Among those who had seen or heard of *Shujaaz*, percentage who had read or seen an issue about teenage pregnancy, relationships, or male responsibility					
Yes	74.6	67.6	57.5	75.5	69.9
No	25.4	31.8	42.5	24.5	30.2
Missing	0.0	0.6	0.0	0.0	0.0
Number of exit interview clients who had seen or heard of *Shujaaz* comic book	**484**	**324**	**299**	**147**	**136**

Table 3.22: Exit interview clients' exposure to Tupange via radio and television programs at endline

Percentage distribution of exit interview clients at high volume/strategic sites by exposure to Tupange radio and television programs, by city, Kenya, 2014

	Nairobi	Mombasa	Kisumu	Machakos	Kakamega
Percentage who had listened to the radio in the previous three months					
Every day	59.9	50.6	68.1	71.3	69.1
At least once a week	27.3	27.1	20.0	24.9	19.7
At least once in two weeks	4.1	7.1	5.2	2.1	3.6
Not at all	8.7	15.1	6.7	1.7	7.7
Missing	0.0	0.1	0.0	0.0	0.0
Number of exit interview clients	**1602**	**1162**	**1158**	**522**	**417**
Among those who had listened in the previous three months, percentage who had heard any FP/child birth spacing information on the radio in the previous year					
Yes	90.5	86.4	93.3	94.9	94.8
No	9.5	13.5	6.7	5.1	5.2
Missing	0.0	0.1	0.0	0.0	0.0
Number of exit interview clients who had listened to the radio in the previous three months	**1462**	**987**	**1081**	**513**	**385**
Among those who had listened in the previous three months, percentage who had heard about and/or listened to the Tupange radio program *Jongo Love* in the previous year					
Yes	20.3	23.2	23.6	14.4	24.2
No	79.7	76.8	76.4	85.6	75.8
Number of exit interview clients who had listened to the radio in the previous three months	**1462**	**987**	**1081**	**513**	**385**
Percentage who had watched television in the previous three months					
Every day	75.1	66.7	59.2	55.6	64.0
At least once a week	14.4	14.5	16.1	19.4	15.1
At least once in two weeks	2.5	4.0	5.4	5.4	1.9
Not at all	8.0	14.8	19.3	19.7	18.9
Number of exit interview clients	**1602**	**1162**	**1158**	**522**	**417**
Among those who had watched in the previous three months, percentage who had seen any FP/child birth spacing information on TV in the previous year					
Yes	91.7	88.9	90.7	89.7	94.7
No	8.1	10.5	8.7	10.0	5.3
Don't know	0.2	0.6	0.5	0.2	0.0
Missing	0.0	0.0	0.1	0.0	0.0
Number of exit interview clients who had watched TV in the previous three months	**1474**	**990**	**934**	**419**	**338**

Table 3.23: Exposure to Tupange internet programs at endline

Percentage distribution of exit interview clients at high volume/strategic sites by exposure to Tupange internet programs by city, Kenya, 2014

	Nairobi	Mombasa	Kisumu	Machakos	Kakamega
Percentage who accessed internet in the previous year					
Yes	23.1	19.4	29.4	28.5	46.3
No	76.5	77.9	64.7	66.7	53.2
Don't know internet, web, email	0.4	2.8	6.0	4.8	0.5
Number of exit interview clients	**1602**	**1162**	**1158**	**522**	**417**
Among those who accessed internet, frequency with which they had accessed internet, including web or email, in previous year					
Every day	42.2	56.9	50.0	48.3	51.3
At least one a week	37.3	33.8	29.7	39.6	38.3
At least once in two weeks	8.9	6.2	6.2	6.7	6.7
Less frequently	11.6	3.1	13.8	5.4	3.6
Missing	0.0	0.0	0.3	0.0	0.0
Number of exit interview clients who accessed internet in previous year	**370**	**225**	**340**	**149**	**193**
Among those who accessed internet, percentage who had seen any messages about teenage pregnancy, relationships, or male responsibility on various internet sites in the previous year*					
Facebook	57.8	56.0	54.1	60.4	66.3
YouTube	15.1	15.1	18.5	21.5	16.6
Tupange/Youth Smart website	6.0	8.4	3.8	1.3	7.3
Shujaaz website	5.7	6.7	4.7	5.4	2.1
Jongo Love Facebook page	3.5	3.1	3.8	0.7	1.6
Jongo Love website	2.2	2.2	2.1	1.3	1.0
None of these, but saw on other internet site	16.8	9.3	11.8	14.1	19.7
Have not seen FP or birth spacing methods on internet	30.3	30.2	33.8	24.8	17.1
Number of exit interview clients who accessed internet in previous year	**370**	**225**	**340**	**149**	**193**

*Multiple responses possible, percentages may not sum to 100%.

reported that they had, with caravan road shows and community meetings the most frequently mentioned Tupange events where clients had heard about FP information.

CHV Exposure, CHV Programs and Outreach Activities

The Ministry of Health has increased the use of Community Health Volunteers (CHVs) in distributing FP commodities, through community-based distribution. CHVs are trained using a comprehensive curriculum that includes FP. CHVs receive specific methods (condoms and oral contraceptives) from their facilities and are tasked with providing information along with the methods to clients during their household visits. Though a majority of the CHVs do not receive any monetary remuneration, they receive incentives in the form of T-shirts, bags, hats, and training for providing services to the clients.

CHV Exposure

CHVs provide information to women on FP methods and their side effects, benefits, and availability. Clients were asked about their interaction with CHVs in the various cities. About one quarter of the clients had been visited by a CHV during the year before the endline survey. Of the clients who reported that they had met with CHVs, between 58 percent (in Nairobi) and 81 percent (in Machakos) reported that they had discussed FP. At least 93 percent of the women who talked with CHVs about FP across all cities discussed FP methods and benefits of using FP; discussions on FP side effects and where to obtain methods and information ranged from 77 percent in Nairobi to 81.6 percent in Machakos and from 95.1 percent in Kisumu to 97.8 percent in Kakamega, respectively. Up to one in five of the women, across cities, reported having ever received oral pills from CHVs among women who met with a CHV as detailed in Table 3.25. About one quarter of women who had been visited by a CHV across cities reported that they had ever received condoms from the CHV. The percentage of women who were ever referred to a health facility by CHVs for FP ranged from 66.7 percent in Nairobi to 80.7 percent in Machakos.

CHV Programs

Health facilities use outreach programs to increase demand for FP services with a focus on "hard-to-reach" populations and the poor. Table 3.26 provides information on facilities that operate outreach activities. More than three-fourths of all Tupange facilities and more than one-third of all non-Tupange facilities had CHVs

Table 3.24: Exposure to Tupange events at endline

Percentage of exit interview clients at high volume/strategic sites by city and type of Tupange event at which they reported having heard information about FP.* Kenya, 2014

	Nairobi	Mombasa	Kisumu	Machakos	Kakamega
Caravan road show event	46.6	45.9	61.3	44.1	48.4
Community meeting	24.0	24.5	20.7	51.2	32.9
Community drama	18.2	18.9	11.4	11.5	13.4
Football competition	8.5	5.8	9.2	4.2	13.7
Beauty contest	9.2	6.6	4.0	9.6	5.8
Boda Boda event	6.1	8.6	14.3	4.2	9.1
Public entertainment event	19.8	13.9	20.8	26.6	13.2
None	40.4	38.6	25.4	25.5	29.0
Number of exit interview clients	**1602**	**1162**	**1158**	**522**	**417**

*Teenage pregnancy, relationships, male responsibility, FP, child birth spacing

Table 3.25: Exposure to community health volunteers at endline

Percentage distribution of exit interview clients at high volume/strategic sites who reported contact with community health volunteers (CHV) by city, Kenya, 2014

	Nairobi	Mombasa	Kisumu	Machakos	Kakamega
Percentage who were visited by a CHV in the previous year					
Yes	29.3	25.3	24.0	26.8	41.3
No	70.7	74.7	76.0	73.2	58.8
Number of exit interview clients	**1602**	**1162**	**1158**	**522**	**417**
Among those visited by CHV, percentage who reported CHV talked about FP in the previous year					
Yes	57.6	76.9	65.5	81.4	80.2
No	42.4	22.8	34.5	18.6	19.8
Missing	0.0	0.3	0.0	0.0	0.0
Number of exit interview clients who were visited by CHV in the previous year	**469**	**294**	**278**	**140**	**172**
Among those who talked with CHV about FP, percentage who discussed particular FP topics in the previous year					
Methods of FP	97.4	98.7	93.4	100.0	97.8
Side effects of FP	77.0	79.2	74.2	81.6	76.1
Benefits of FP	92.6	95.1	95.6	98.3	97.1
Where to obtain FP	97.0	96.5	95.1	98.3	97.8
Other topic	14.4	26.1	7.7	2.6	14.5
Number of exit interview clients who were visited by CHV and talked about FP in the previous year	**270**	**226**	**182**	**114**	**138**
Among those visited, percentage who ever received oral pills for FP from CHV					
Yes	15.6	20.1	6.8	18.6	14.0
No	84.4	79.9	93.2	81.4	86.1
Number of exit interview clients who were visited by CHV in the previous year	**469**	**294**	**278**	**140**	**172**
Among those visited, percentage who ever received condoms for FP from CHV					
Yes	27.3	23.8	22.7	30.7	30.2
No	72.7	76.2	77.3	69.3	69.8
Number of exit interview clients who were visited by CHV in the previous year	**469**	**294**	**278**	**140**	**172**
Among those visited, percentage who were ever referred by a CHV to a health facility for FP					
Yes	66.7	76.5	68.4	80.7	80.2
No	33.3	23.5	31.7	19.3	19.8
Number of exit interview clients who were visited by CHV in the previous year	**469**	**294**	**278**	**140**	**172**
Among those visited, percentage who were told about or referred by a CHV to a special event being held outside a health facility where she could access FP					
Yes	38.2	46.6	39.2	24.3	45.9
No	61.8	53.4	60.8	75.7	54.1
Number of exit interview clients who were visited by CHV in the previous year	**469**	**294**	**278**	**140**	**172**
Among those visited, percentage who were told about or referred by a CHV to a special event being held at a health facility where she could access FP					
Yes	41.2	56.1	42.1	30.7	43.6
No	58.9	43.9	57.9	69.3	56.4
Number of exit interview clients who were visited by CHV in the previous year	**469**	**294**	**278**	**140**	**172**

attached to them. Among all facilities with any CHVs, 94.9 percent of Tupange facilities and 79.4 percent of non-Tupange facilities had CHVs trained in FP. Similarly, 89.9 percent of Tupange facilities and 76.2 percent of non-Tupange facilities had CHVs who provide FP commodities.

Health facilities with a CHV program were asked if they had CHVs who provide commodities. Results show (Table 3.27) that 86 percent of facilities have CHV who provide commodities. 89.9 percent of Tupange-supported facilities and 76.2 percent of non-Tupange-supported facilities had CHWs who provide FP commodities. Among all such facilities, 95.3 percent provided condoms and 88.4 percent provided pills. Regardless of facility type, provision of injectables, EC, and SDM/CycleBeads was minimal, between 0 and 3.1 percent. Tupange provides various types of compensation to CHVs. Three-fourths of the facilities provided T-shirts, and more than one-third of facilities provided trainings, salary, or bags as compensation to their CHVs. Moreover, various organizations/programs sponsored CHVs at facilities. The most common sponsors were Tupange (sponsoring 56.6 percent), AMUA Tupange (14.9 percent), APHIA Plus (11.8 percent), and Marie Stopes (10.9 percent). Table 3.27 details CHV activities at health facilities.

Outreach Activities

More public facilities reported having conducted outreach programs at endline than at baseline; similar trends were seen among private facilities in Kisumu, Kakamega, and Machakos, though changes were small, as detailed in Table 3.28.

The percentage of facilities with CHVs at endline increased relative to baseline data (Table 3.28). Furthermore, the percentage of facilities that reported that their CHVs were trained in FP methods and provision of FP commodities had increased by endline.

Table 3.29 provides information on the percentage of Tupange and non-Tupange facilities with outreach activities at endline. Less than half of all the facilities (54.2 percent of the Tupange and 29.5 percent of the non-Tupange) had outreach programs. In some facilities, Marie Stopes/Tupange had supported clinical teams to visit health facilities in order to provide long-acting or permanent methods of FP. Most of the Tupange facilities (91.7 percent) and a few of the non-Tupange facilities (19.2 percent) received such supportive visits at endline. Among all facilities that had Marie Stopes/Tupange-supported visits, 84.4 percent of the facilities had service providers who participated in long-acting or permanent methods provision during these visits.

IEC Materials on FP

Data was collected on the availability and use of information, education, and communication (IEC) materials at health facilities. Table 3.30 presents the percentage of facilities with IEC materials for clients or service providers bearing the Tupange logo, listed according to receipt or nonreceipt of Tupange support. Tupange-supported facilities are much more likely to have IEC materials than non-Tupange facilities. Similar results were noted in matched facilities, as well. Matched facilities (as noted above) are those that had completed facility audits at both the baseline and endline time points.

Demonstration models and samples of FP methods were the most widely available FP IEC materials across the facilities. Posters and clothing, caps, bags, lab coats, and aprons were also relatively common IEC materials.

Table 3.31 shows the results of the IEC assessment across the cities by facility type. Overall, the majority of the public facilities had IEC materials displayed and available for use, while the same was not true of the private facilities. At endline, more than 90 percent of the private facilities in Kisumu, Machakos, and Kakamega lacked IEC materials, with the exception of samples of FP methods and demonstration models; samples of FP methods and demonstration models were available in about four out of five public facilities, compared to three out five of private facilities across cities.

Table 3.26: Community health volunteers

Percentage of facilities that have outreach activities, by receipt of Tupange support, Kenya, 2014

Tupange support	Total number of facilities	Percentage of facilities with CHVs	Among facilities with CHVs: Total number of facilities	Among facilities with CHVs: Percentage of facilities that report that CHVs are trained in FP	Among facilities with CHVs: Percentage of facilities where CHVs provide FP commodities
All facilities					
Tupange	**201**	78.6	**158**	94.9	89.9
Non-Tupange	**176**	35.8	**63**	79.4	76.2
Matched facilities					
Tupange	**113**	87.6	**99**	96.0	94.9
Non-Tupange	**144**	34.7	**50**	84.0	84.0

Table 3.27: Exposure to CHV programs by exposure to Tupange program

Among those facilities with a CHV program, percentage that have specific CHV program activities at endline, by type of facility, Kenya, 2014

	All facilities	Tupange-supported (all facilities)	Non-Tupange-supported (all facilities)	Tupange-supported (matched)	Non-Tupange-supported (matched)
Percentage of facilities with CHVs who provide commodities	86.0	89.9	76.2	94.9	84.0
Among facilities with CHVs who provide commodities, the percentage who provide					
Injectables	0.5	0.7	0.0	0.0	0.0
Pills	88.4	93.0	75.0	91.5	73.8
EC	1.6	1.4	2.1	1.1	2.4
Condoms	95.3	94.4	97.9	94.7	97.6
SDM/CycleBeads	2.1	2.8	0.0	3.2	0.0
Number of facilities where CHVs provide any commodity	190	142	48	94	42
Percentage that provide CHVs with various types of compensation					
Monthly salary	38.9	34.2	50.8	29.3	46.0
T-shirt	74.7	76.6	69.8	77.8	72.0
Hat	32.6	35.4	25.4	40.4	30.0
Bag	34.8	32.9	39.7	36.4	46.0
Apron	30.3	36.1	15.9	32.3	16.0
Pins/badges	1.8	2.5	0.0	3.0	0.0
Training	43.4	43.0	44.4	50.5	46.0
Bicycle	6.8	4.4	12.7	6.1	12.0
Mobile phone	0.0	0.0	0.0	0.0	0.0
Percentage of facilities with CHVs sponsored by					
Tupange	56.6	71.5	19.0	76.8	18.0
PSI/TUNZA	8.1	3.8	19.0	6.1	24.0
FHOK	2.3	1.3	4.8	2.0	6.0
Marie Stopes	10.9	9.5	14.3	5.1	16.0
IntraHealth	0.0	0.0	0.0	0.0	0.0
APHIA Plus	11.8	12.0	11.1	16.2	8.0
AMUA Tupange	14.9	20.3	1.6	15.2	2.0
AMUA only	4.1	4.4	3.2	2.0	4.0
MOH	9.0	10.1	6.3	9.1	6.0
GTZ/GIZ	0.0	0.0	0.0	0.0	0.0
Total number of facilities with CHV programs	**221**	**158**	**63**	**99**	**50**

Table 3.28: Exposure to outreach programs

Percentage of facilities that have outreach activities, by city and managing authority, Kenya, 2011, 2014

City and managing authority	Total number of facilities	Percentage of facilities that conduct health outreach programs	Percentage of facilities with CHVs	Among facilities with CHVs		
				Total number of facilities	Percentage of facilities that report that CHVs are trained in FP	Percentage of facilities where CHVs provide FP commodities
Nairobi baseline						
Public	**41**	78.0	87.8	**36**	47.2	30.6
Private	**68**	35.3	48.5	**33**	66.7	42.4
Nairobi endline						
Public	**52**	80.8	94.2	**49**	93.9	91.8
Private	**121**	26.4	52.9	**64**	89.1	78.1
Mombasa baseline						
Public	**16**	87.5	93.8	**15**	73.3	53.3
Private	**44**	25.0	34.1	**15**	60.0	26.7
Mombasa endline						
Public	**22**	90.9	95.5	**21**	100.0	100.0
Private	**57**	12.3	54.4	**31**	90.3	90.3
Kisumu baseline						
Public	**18**	77.8	94.4	**17**	35.3	29.4
Private	**36**	30.6	38.9	**14**	42.9	21.4
Kisumu endline						
Public	**18**	94.4	100.0	**18**	94.4	94.4
Private	**47**	31.9	38.3	**18**	66.7	61.1
Machakos baseline						
Public	**5**	80.0	60.0	**3**	0.0	66.7
Private	**25**	24.0	4.0	**1**	100.0	100.0
Machakos endline						
Public	**10**	90.0	70.0	**7**	100.0	100.0
Private	**26**	26.9	23.1	**6**	83.3	66.7
Kakamega baseline						
Public	**8**	50.0	50.0	**4**	50.0	50.0
Private	**18**	27.8	16.7	**3**	66.7	66.7
Kakamega endline						
Public	**8**	87.5	75.0	**6**	100.0	100.0
Private	**16**	31.3	6.3	**1**	100.0	100.0

Table 3.29: Exposure to outreach activities by exposure to Tupange program

Percentage of facilities with specific outreach activities at endline by receipt of Tupange support, Kenya, 2014

Outreach activity	All facilities	Tupange-supported (all facilities)	Non-Tupange-supported (all facilities)	Tupange-supported (matched)	Non-Tupange-supported (matched)
Percentage of facilities with an outreach program	42.7	54.2	29.5	68.1	27.8
Percentage of facilities where Marie Stopes/ Tupange has supported visits of clinical teams to provide LAPM	47.5	69.2	22.7	83.2	21.5
Total number of facilities	**377**	**201**	**176**	**113**	**144**
Among those that conduct an outreach program					
Percentage of facilities with an outreach program that has ever had Tupange-supported outreach	68.3	91.7	19.2	97.4	20.0
Total number of facilities that conduct outreach programs	**161**	**109**	**52**	**77**	**40**
Among those that had Marie Stopes/Tupange-supported visits					
Percentage with service providers who participated in LAPM provision during these visits	84.4	85.6	80.0	84.0	77.4
Total number of facilities that had Marie Stopes/Tupange-supported visits	**179**	**139**	**40**	**94**	**31**

Table 3.30: Exposure to IEC materials at endline

Percentage of facilities that stock IEC materials with Tupange logo at endline, by receipt or nonreceipt of Tupange support, Kenya, 2014

Type of IEC Material	All facilities	Tupange (all facilities)	Non-Tupange (all facilities)	Tupange (matched facilities)	Non-Tupange (matched facilities)
Posters	40.3	68.2	8.5	75.2	9.0
Informational flip charts	17.8	30.8	2.8	32.7	3.5
Brochures/pamphlets	18.3	32.3	2.3	37.2	1.4
Information sheets	17.0	29.4	2.8	33.6	2.8
Job aids	18.3	32.3	2.3	40.7	1.4
Demonstration models (not Tupange-specific)	52.8	65.2	38.6	82.3	39.6
Counseling cards	10.6	18.4	1.7	21.2	2.1
Samples of FP methods (not Tupange-specific)	71.6	79.1	63.1	87.6	61.1
Clothing, caps, bags, lab coats, aprons	41.9	65.2	15.3	78.8	16.0
Bracelets	1.9	3.5	0.0	6.2	0.0
Total number of facilities	**377**	**201**	**176**	**113**	**144**

Table 3.31: Exposure to IEC materials at endline by city

Percentage of facilities where IEC materials with Tupange logo were observed at endline, by city and managing authority, Kenya, 2014

	Nairobi		Mombasa		Kisumu		Machakos		Kakamega	
Types of IEC materials	Public	Private	Public	Private	Public	Private	Public	Private	Public	Private
Posters	63.5	38.8	86.4	45.6	66.7	2.1	60.0	0.0	87.5	6.3
Informational flip charts	38.5	17.4	22.7	10.5	27.8	2.1	50.0	3.8	37.5	0.0
Brochures/pamphlets	25.0	19.0	40.9	21.1	22.2	0.0	40.0	0.0	50.0	0.0
Information sheets	23.1	12.4	59.1	22.8	22.2	2.1	30.0	3.8	25.0	0.0
Job aids	44.2	9.1	59.1	17.5	27.8	0.0	40.0	0.0	37.5	0.0
Demonstration models (not Tupange-specific)	88.5	48.8	86.4	47.4	61.1	31.9	70.0	34.6	50.0	12.5
Counseling cards	15.4	4.1	45.5	12.3	16.7	0.0	20.0	11.5	25.0	0.0
Samples of FP methods (not Tupange-specific)	92.3	66.1	95.5	56.1	88.9	63.8	100.0	73.1	75.0	50.0
Clothing, caps, bags, lab coats, aprons	82.7	37.2	81.8	40.4	50.0	2.1	80.0	11.5	75.0	12.5
Bracelets	7.7	0.8	4.5	0.0	0.0	0.0	0.0	0.0	12.5	0.0
Total number of facilities	**52**	**121**	**22**	**57**	**18**	**47**	**10**	**26**	**8**	**16**

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Appendix A: Study Personnel

Principal Investigators

Elizabeth Bukusi	Kenya Medical Research Institute, Research Care and Training Program, Kenya
Ilene Speizer	Department of Maternal and Child Health, The University of North Carolina at Chapel Hill

Technical Survey Coordinators

Elizabeth A. Bukusi	Local PI , KEMRI-RCTP
Mariciana A. Onono	Co PI, KEMRI-RCTP
Serah W. Gitome	Co PI, KEMRI-RCTP
Elijah Asadhi	M&E Specialist
Kevin Kamolloh	Survey Coordinator, KEMRI-RCTP
Ilene Speizer	PI, The University of North Carolina at Chapel Hill
Lisa Calhoun	Technical Officer, The University of North Carolina at Chapel Hill
John Kennedy Otsola	MLE Kenya Country Manager, IntraHealth International
Mercelline Ogolla	MLE Deputy Country Manager, IntraHealth International

Field Survey Teams

Nairobi

Mollie Dette	City Manager
Alfred Odira	City Manager
Evans Otieno Nyambok	Field Editor
Sheila Wanyanga	Field Editor
Annebell W. Kihuha	MLE Regional Technical Coordinator
Ann Njeri	MLE Field Quality Assurance Supervisor

Nairobi Research Assistants

Wendy Kithia	Elcy Jeptoo Birgen
Dolphine Buoga	Jacqueline N. Nambiro
Erolls C. Sigei	Michael Nakwaya
Maureen Olwero	Sheila Abura Awino
Milicent Oundo	Elizabeth Adhiambo Okoko
Valley Auma Obure	Lilian Akinyi
Susan Muthoni	Conceptor Ngode
Carolyn Muringa	Shalet Jebiwot
Kennedy Osano	Kelvin Michael
Bernard Mboya	Brosir Maparo Maraka
Dennish Ongola	Janet Kulola Mwakodi

Mombasa

Emily Juma	City Manager
Shadrack Muramba	Field Editor
Sadiq Wasanga	MLE Regional Technical Coordinator
Kirleen Carolyne Athiambo	MLE Field Quality Assurance Supervisor

Mombasa Research Assistants

Emilyn Chari	Simon Otieno
Edith Onkoba	Lina Kache Kombe
Promilla Moindi	Risper Adhiambo
Lilian N. Mbugua	Aisha Hamid Mohammed
Rita Mudza Mwahunya	Sarah Githaiga
Amina Ali Juma	Samuel Mvovi Mazarimu
Nassir Abass Mohammed	Shadrack Karisa Muramba

Kisumu

Yusto Okembia	City Manager
Linder Ogweno	Field Editor
Bernard Nyerere	MLE Regional Technical Coordinator
Perez Lola Siambe	MLE Field Quality Assurance Supervisor

Kisumu Research Assistants

Emily Anyango	Wilson Anyona
Faith Beryl Kasoly	Olive Onyango
Farida Oluoch	Winny Atieno
Jacinter Ogolla	Amon Ojwang
Moses Okombo	Stephen Okumu

Machakos

Hellen Gitau	City Manager
Grace Njeri	Field Editor
Pauline Nthambi	MLE Regional Technical Coordinator
Marygoret Munyala	MLE Field Quality Assurance Supervisor

Machakos Research Assistants

Samuel Muoki Mutua	Mary Beatrice Kiende
Thomas Thuku Ndei	Bevelyne Mibei
Irene Kameme	Teresa Sakwa
Sarah Muoki Mumo	Phoebe Mutila Kisavi

Kakamega

Peter Manwari	City Manager
Naomi Ashiono	Field Editor
Agnes Onyisa	MLE Regional Technical Coordinator
Keverenge Hillary Vigatsi	MLE Field Quality Assurance Supervisor

Kakamega Research Assistants

Nancy Wasiela	Mildred Ageida
Peris Mosita	Ann Adisa
Julienna Omoro	Nickson Machani
Rodgers Ochieng	

Data Processing – Technical Team

Aimee M. Benson	Overall Technical Lead, System Developer, The University of North Carolina
Anthony Matovu	System Developer
Ferdnand O. Motari	Data Manager, RCTP
Elijah Asadhi	M&E Specialist

Data Entry Clerks and Editors

Pamella Akinyi Oluoch	Leah Akinyi Obath
Doreen Auma Otieno	George Ocharo Ouma
Onyango Victor Okik	Ong'injo Nicholas Ochieng
Nicholas Oguba Obwamo	Millicent Adhiambo Oronje
Vivian Akinyi Odhiambo	Timothy Kwena
Pauline Betty Ouko	Annabell Dollah Omollo
Christine Khisa Barasa	Lydia Achieng
Elisha Omondi Migawi	

Survey Report Writing Participants and Editors

MLE

Mercelline Ogolla
John Otsola
Essete Kebede
Lisa Calhoun

KEMRI-RCTP

Maricianah Onono
Serah Gitome
Elijah Asadhi
Ferdnand O. Motari
Kevin Kamolloh