Documentation of selfcare pilot activities in Bungoma County

A Qualitative Review of 18 months (July 2022 to December 2023) of Initiatives by the Government and Implementing Partners

By Reproductive Health Network Kenya

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Background

The Kenya Government through the Division of Reproductive Health developed the Guidelines on Self-care in Reproductive Health and signed them off for use in May 2023. The Government of Bungoma County however allowed partners to pilot the Self-care (SC) activities from July 2022 as the guidelines were being finalized.

A number of implementing partners including RHNK, Ipas, KMET and White Ribbon Alliance went to the ground and started working with the county government to implement SC activities in three areas: abortion, family planning and HIV. Implementing partners did trainings and sensitization with County Health Management (CHMT), service providers, pharmacy workers, community health workers and community groups. They also connected service providers at the ground with suppliers of commodities from the private sector.

Each implementing partner had its SC work plan which they implemented in the pilot period. Below is an example of an implementing partner scope of activities:

RHNK Plans For the Pilot	
1.	Stakeholder Engagement and Mobilization: actively engage with key stakeholders, including community leaders, county health officials, and healthcare facilities, to introduce and garner support for SC.
2.	Training and Capacity Building: train healthcare providers, pharmacists, and CHVs on the implementation of the Reproductive Health Self-care Guideline so as to support individuals in practicing safe.
3.	Rollout of Toll-Free Hotline: establish a toll-free hotline specific to Bungoma County, enabling individuals to seek SRH services and information easily.
4.	Advocate for integration of SC into regular services in the county

Just like RHNK, the other partners had activities with the scope to:

1. Support the county to align the policy environment to support self-care
2. Train service providers in hospitals, pharmacies and community (Community Health Promoters (CHPs)) to be supportive of SC initiatives by community members
3. Create awareness and competence in community members to make SC decisions by increasing their self-awareness and self-diagnosis and treatment capabilities
4. This assignment was commissioned to document the experiences of piloting SC in Bungoma county by exploring perspectives of all stakeholders. Results of the documentation are to be used to improve SC programs and contextualize it going forward given that it is a new program in Kenya with experiences from other countries.

The Guideline

At the national level there is Core Group and Stakeholders Group which steer national implementation of SC. All the groups implementing the pilot in Bungoma are members of the Stakeholder's Group.

The guideline focuses on improving self-care for:

- Maternal health
- Abortion
- Family Planning
- HIV and STIs

After the formal sign-off a launch was planned but never happened because of agitation by opposition groups.

Methodology of the documentation

The documentation was carried out from 19th to 21st of December 2023. Given the nature of the work and partners involved, the core of the information gathering for the documentation was exploratory and involved:

i. Five focus group discussions (FGDs). The FGDs were done face to face. The groups were as follows:

   a) Nine community members from Webuye East and Webuye West Sub-Counties – venue a church compound
   b) Twelve youth from Webuye East and Webuye West Sub-Counties – venue a church compound
   c) Seven community health promoters from Webuye East Sub-County – venue a church compound
   d) Seven facility-based service providers running private clinics in three sub-counties of Bungoma County; the meeting venue was a clinic in Misikhu, a small centre on Webuye – Kitale Road
   e) Twelve members of County Health Management Team with expertise in sexual, reproductive, maternal, HIV and adolescent health as well as health promotion and health policy. The venue was a hotel in Bungoma town

ii. Key informant interviews with the following:
   a) A pharmacy technologist – this was done face to face in the pharmacy of the provider in Likuyani centre on Webuye – Kitale Road
   b) A representative of each of two implementing partners – these were done virtually. Interviewees were project leaders who implemented SC projects directly with communities.

An FGD took on average 1 to 3 hours and took the form of experience sharing guided by the pre-determined open-ended question guides. Similarly, the KIIs were based on experience sharing.

The interviews were recorded using a recorder with a phone back-up. Field notes were also taken by the research assistant. Face to face sessions provided opportunity for researchers to study body language and probe further issues that participants found difficult to discuss. The study team had a chance to discuss and agree on messages that the interviewees wanted to pass after every interview.

FGD with community members in Webuye town

Results

The findings of the FGDs and KIIs were grouped into themes. Nine dominant themes have been identified and provide key learnings for the future as follows:

i. Need for a joint understanding of self-care by all stakeholders

According to the National Self-care Guidelines, self-care refers to the ability of individuals, families, and communities to promote and maintain health; prevent disease; and cope with illness with *or without* the support of a healthcare provider. The guidelines anticipate that self-care will enable people to exercise their autonomy, power, and control over their health, and improve their health and well-being. The guidelines categorize individual actions into self-awareness, self-testing, and self-managed care.

We asked stakeholders their understanding of self-care. This is because they can only implement what they understand. The understanding of self-care was as varied as the number of partners asked. Community members and the youth said they were not aware of such an initiative by the Ministry of Health. Similarly, CHPs expressed similar sentiments.

"We have never heard of self-care, possibly we are doing it and calling it other names," FGD CHP participant.
On defining and explaining what self-care is, some CHPs confirmed that they had been trained on some aspects of reproductive health that qualified as self-care. They however had not seen the guidelines.

In reference to the county management, partners said that there was goodwill for SC. They were however worried that the understanding of the definition of SC by the county could be narrow and not as spelt out in the guidelines. This became clear when, in the FGDs, some CHMT members wondered how safe self-care was both legally and medically.

"It is only after we showed them how we would twin the pharmacies with service providers and have the service providers examine the patient and give prescriptions for pharmacies to dispense and how we would follow the law by service providers recommending the abortion that they allowed us to do the pilot," a KII participant.

This approach initially sanctioned by the county takes away the autonomy of the patient which is at the core of self-care. It puts power back to the health worker. During the pilot it became impossible to follow the county approved approach and still implement self-care.

"Over time the process (approved by MoH) has changed when it is a first trimester pregnancy. The whole process only applies when a pregnancy is big otherwise people know the drug they want, pick it from a pharmacy without a prescription and go," a KII participant.

In fact the definition is metamorphosizing as the pilot matures. Some partners are bold and determined to make it work and are in fact sticking to the original definition.

"It is about the woman taking lead, going to the chemist to buy the drug, after having a successful abortion choosing the contraceptive of their choice," KII participant.

It is also becoming clear that self-care cannot be divorced from the health system even if people have their autonomy. Health workers must understand what it is and commit to providing information, commodities, and making referral possible. They must ensure that products for self-care are of good quality.

ii. Clarity on the status of self-care policy

The national Ministry of Health signed off the Self-care Guideline document, but the launch did not happen due to agitation by the opposition. The signing was however taken to be a formal approval for implementation. Bungoma County CHMT did not however have this understanding. The CHMT is aware that the guidelines were developed. They went ahead and formed a TWG on SC which has not had much activity. They know that there was a launch to be done but which did not happen. They have been waiting for the launch after which they would have a process of domesticating the guideline to the county.

"Once we have the guidelines launched we will domesticate them to Bungoma County, each county is different. For now we wait for the Ministry to launch the guidelines then we can start," FGD Member of CHMT Bungoma.

That notwithstanding, the County is undertaking some self-care activities within the umbrella of PHC. They are also aware that there are some partners interested in SC but that the partners are not really undertaking SC activities as yet. They know that partners such as KMET and Ipas are implementing some projects, but they have not considered these to be SC.

We explained to CHMT that the National Government had given a go ahead for implementation of the guidelines. This was news to them.

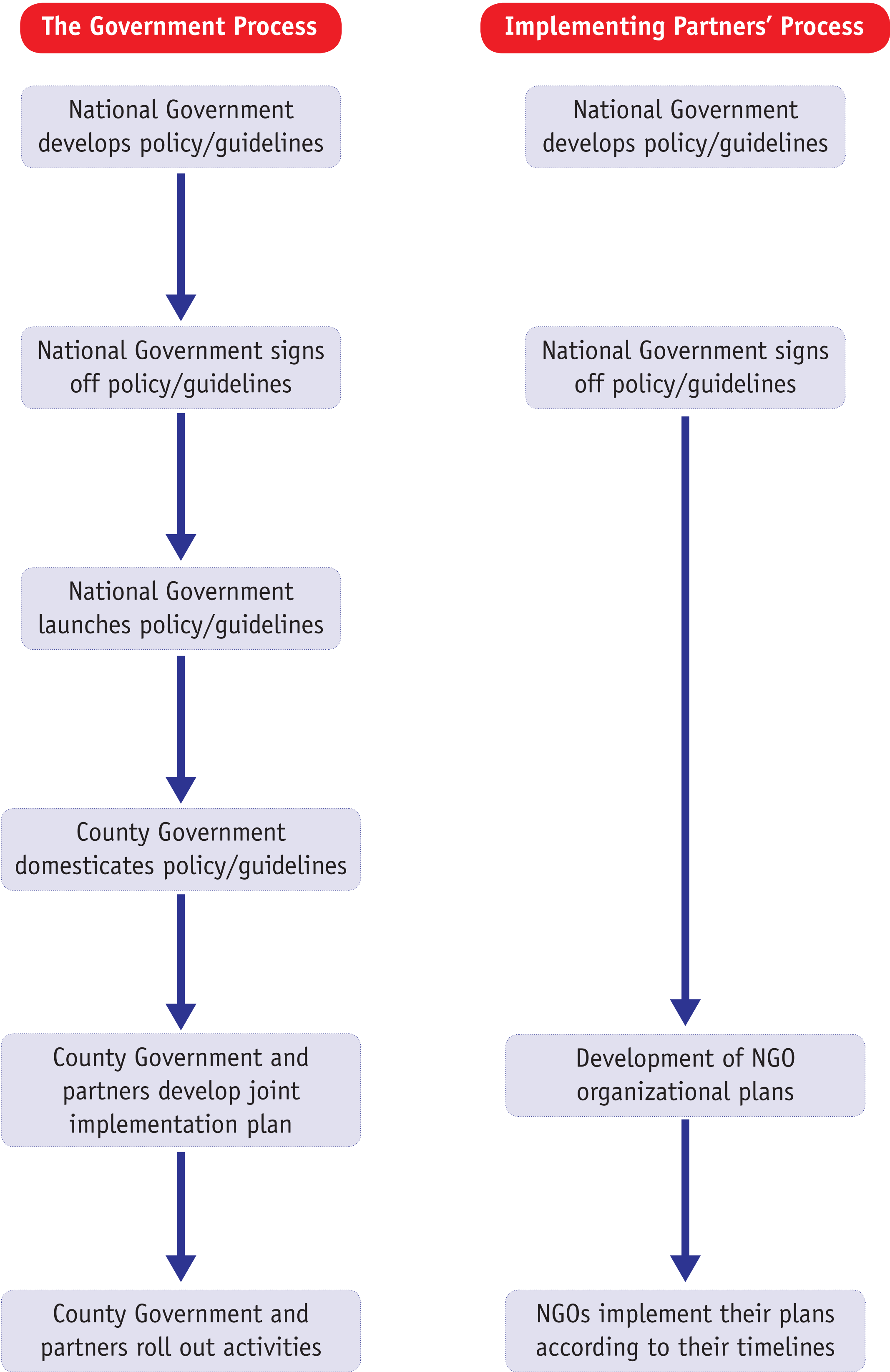
"If they have given an okay for us to implement the guidelines then that is a new development and we can now think of domesticating it," FGD Member of the County CHMT.

The NGO partners do not have the same understanding of the policy situation concerning self-care. Their understanding is that the guidelines are in force and so they are going ahead with implementation.

"I think the self-care guidelines were launched and operationalized. The combi park was listed as an essential drug and for me that means it was launched," KII NGO partner participant.

The following flow chart summarizes the current understanding on how self-care guidelines should be implemented in the county as understood by the different stakeholders:

Fig. 1: The Current Understanding of the Process for Rolling Out Self-care Policy/Guidelines



At this point the county government prioritizes domestication as the next stage in implementation while NGO implementing partners are already implementing activities. The county takes the NGO activities to be projects under PHC focusing on reproductive health and are happy to have them continue.

Asked how their activities would be affected if they followed the county government policy process, the NGOs are apprehensive that it might make implementation of some activities difficult.

"We know that the pharmacies are going beyond their defined roles. The government, being a watchdog, may slow the progress by stopping what is going on now if they actively take leadership for SC. The PHC agenda that is being prioritized could be an entry point," KII participant.

In fact, post-abortion care services could suffer serious setbacks if the County Government takes lead in implementing guidelines because despite the High Court reinstating abortion guidelines, they still believe that abortion guidelines document is not legal.

"Abortion guidelines were withdrawn so we are not able to provide the services," FGD CHMT participant.

In fact, CHMT was especially worried about any risks that can arise out of self-care activities and expressed a subtle need to regulate what people are allowed to do.

"We also need to limit what you can self-prescribe and self-inject, it can be dangerous," FGD CHMT Participant.

iii. Hiccups in coordination of self-care interventions at all levels

The county has already formed the TWG on self-care. Key partners including implementing NGOs however said that they are not represented and that this may leave their interests out.

"Private service providers are not represented in the TWG. This means that we do not have a platform to raise our concerns. There is need for the government to consider us as an important partner in achieving the health objectives of the county," FGD service provider participant.

But the TWG is yet to start working. As such, there is no active central coordination of self-care activities in the County. Participants expressed concern over this lack of coordination. The CHMT, on the other hand, was of the opinion that the county should be a convener but that there should be a lead partner to push for and facilitate coordination.

"While the government convenes the implementation, we need a lead partner to back the implementation, especially in supporting logistics," FGD CHMT participant.

NGOs anticipate coordination to continue being a challenge because of the differences in planning periods. NGO planning times do not always go in tandem with the government

planning for the year. Further, each NGO has different donor planning, implementation and reporting timelines. Even when the government takes a stronger role in coordination, therefore, it may not always work perfectly.

"Coordination is not there. We implement depending on what the donor wants," NGO KII participant.

Even the implementing NGOs are unable to coordinate with each other. They have deliverables that they have promised their donors and have timelines to meet. Coordinating with others could be time consuming.

"Coordination only happens among (NGO) implementers if the donor is the same otherwise everyone does their own thing," KII NGO participant.

Participants however recommended that it would be better for implementing partners to agree to share workplans, co-implement activities and meet MoH county staff jointly. They also suggested that it would be better to train providers jointly.

"If we are trained together, i.e. the service providers in the public and private facilities as well as pharmacists, we will coordinate better at the ground. Right now there is a problem on how we work together in serving patients," FGD service provider participant.

That said, there is one area of coordination that is working - that between pharmacies and suppliers of commodities. This has ensured continued flow of commodities in the county.

"The coordination between suppliers and referral sites is going well because the connections were made during the training," KII Pharmacy tech.

iv. Professional Turf Wars May Derail Implementation of Self-care

For self-care to work, CHPs, pharmacists and service providers in hospitals and clinics must commit to sharing knowledge among themselves supported by policy makers in the county and be able to pass the same knowledge to members of the community for their use in self-awareness, self-diagnosis and self-treatment. The documentation team however found an on-going difficulty in sharing knowledge and working together among the teams.

Service providers do not want to share knowledge of medicines and how to use them with CHPs. As such, CHPs have very little knowledge of the treatments.

"We do not know the tablets they use for abortion. We leave it to the doctor to give them. We do not know if the pharmacies also have the medicine," FGD CHP participant.

The reason for denying the CHPs knowledge is that they can misuse it.

"If the CHPs get to know what we do they will misuse the knowledge and offer unpost-abortion

cares. We don't allow them in the consultation rooms because once they know what we give or do to patients they can easily misuse it," FGD service provider participant.

Service providers, on the other hand, do not believe that the pharmacy workers are doing things correctly. As such they have previously warned patients to avoid them.

"I went to the pharmacy and they injected me with the family planning injection. The next time I went to the hospital the doctor told me that it is wrong to get the injection from the pharmacy, that the pharmacist is only interested in money and that we should avoid them," FGD Community participant.

At the same time there is suspicion between County health officials and private service providers. Private service providers feel that they are not appreciated and that they are always suspected of doing wrong things.

"Support of the government to service providers is weak. There is a lot of suspicion. They need to treat us well because we are all serving the community." FGD private service provider participant.

The same sentiments are expressed by private pharmacy operators towards public health officers.

"They (public health officers) always pass around looking for fault and threatening to take us to court yet we are trained in the same institutions and we both know what is right," KII Pharmacy technologist.

These turf wars are a hinderance to health workers sharing information and jointly building capacity of community members which is important in the success of self-care.

v. Difficulties in reporting of self-care data

Through the initiatives of implementing partners, self-care service uptake is happening. All the three service areas have some form of services taking place. The problem is that data is not being fully captured and reported in the DHIS. The CHMT is very much aware of this.

"Abortion is happening but we do not have the figures, they are somewhere but we have not fine- tuned the numbers," FGD CHMT participant.

The problem of reporting post-abortion care data is the most challenging. This is because the current DHIS does not have indicators for post-abortion care.

"Some of our facilities are offering CAC but the data is not reported in DHIS, we only report PAC because the policy does not allow us to provide CAC. We have people trained to offer CAC but they cannot boldly come out to talk about it and report," FGD CHMT participant.

With trainings of pharmacy workers to offer MA, the number of post-abortion cares could have gone up but this is not reported anywhere. The data from pharmacies is especially difficult to capture because they have multiple sources of MA drugs and it is therefore hard to know how many doses are being consumed in the county.

"The cases are common, I see between 5 and 10 in a month," KII Pharmacy tech.

Where the drugs have been procured from NGO partners, the pharmacy reports to the NGO directly.

"I report my data to the NGO that supports me. There are no channels to report to the government," KII Pharmacy tech.

If the pharmacies were to report they would need to be given an MFL number like is done for clinics and hospitals. Another possibility is to make them as an outreach site of a facility with MFL number so that they report to the facility. Further, the pharmacy workers would need to be trained on reporting since this has not been part of their mandate.

"Pharmacies are also not trained to provide reports, they may find it as a waste of time," KII participant.

In this function of reporting, the CHPs are way ahead of the pharmacy workers. They are trained and given reporting tools. They submit their data to a designated health facility. Asked if pharmacy workers could undergo the same training on reporting, the pharmacy workers reported that the public health department would not allow it since it is not a government policy. Possibly the Pharmacy and Poisons Board working with the National Government could agree on how to resolve the reporting issue since pharmacies offer a good proportion of services in communities.

For clinics and hospitals, reporting of maternal health, FP, HIV and PAC services is well streamlined and is done to the county monthly. The problem of reporting data on post-abortion care remains a challenge. In fact, if one reports high PAC cases they may be sanctioned and accused of performing illegal abortions.

"Reporting abortion data or high PAC numbers makes the county management question what is going on in the clinic, it can land one in trouble," FGD service provider participant.

Probed further if anyone has ever been punished for reporting high PAC number, service providers confirmed that this has never happened and that it is just fear of being victimized that sometimes make them hesitate to provide data.

Just like the pharmacy workers, the clinic and hospital service providers therefore only report post-abortion care data to the NGOs that are supporting this service.

The current status of reporting of data is well summarized by one key informant as follows:

"MoH only has tools for PAC data. We give them that. MA data just goes to the donor. For FP, the pharmacies are twinned with a facility with MFL and report the data to them. But this brings discrepancies because the pharmacy may dispense drugs that the MoH has not provided. It is recorded as donation from the pharmacy. On average our organization is serving 120 MA cases in Bungoma County and that data goes to our donor, (not the DHIS)," KII NGO partner participant.

vi. Sustainability of self-care including commodities and supplies

The main direct costs to the patient in self-care are two: purchase of commodities that are not available to them for free; and treatment costs in referral sites when home treatment is not adequate. The costs of building capacity of community members and realigning polies are born by the county or NGO partners.

Except for a few FP commodities, currently patients meet costs of commodities through out of pocket payment. These include the costs of test kits for pregnancy and HIV.

"They buy pregnancy test kits at the pharmacy. Also MA drugs, antibiotics, pain management drugs and post-abortion FP," KII NGO partner participant.

"For HIV kits for self-testing people buy them from pharmacies but they can also get them for free in the government facilities," FGD CHMT member.

MoH supplies of HIV self-testing kits is not however consistent. In almost all cases users purchase the kits from pharmacies.

"This whole year we have received the testing kits only once and even then we each got one, maximum two per CHP. What can you use that for if you have 50 to 100 households to care for? Maybe you use it to do your own self-test," FGD CHP participant.

MA drugs are only available through pharmacies right now. Both Misoprostol alone or the combi pack are available. The common practice is that pharmacies do not keep the drugs in the shelves, they order on demand or keep the drugs in their personal handbags or at home. This is to avoid victimization when inspectors from the regulator visit the pharmacies. This arrangement can however delay care as many patients may not have the patience to wait.

"They do not keep the stocks in their premises for legal safety reasons. They can be in problems if they are caught with it; they order the drugs on demand. The drug arrives after 24 hours. The user who is in a hurry may not wait." KII participant.

Although the pharmacies purchase the MA drugs at a controlled price from suppliers/NGOs, there is no price control to patients.

"There is no recommended price to the patient. They decide what to sell it at which includes taking care of any possible complications that may arise in the course of treatment," KII participant.

The cost of the MA drug to the patient, on average, is 8 to 10 times more than what the pharmacies get it at. This could create a barrier to care and increase the disparity between the poor and the rich in accessing abortion services.

Other than pricing, service providers are worry of the quality of MA drugs in the market.

"I have noted that the MA drugs from (*some*) of our NGO partners do not meet quality standards and that if you give them to a patient they are likely to fail. That can mean prolongation of the service which has many social and legal consequences." FGD Service provider participant.

The county is aware of the commodity supply issues at service delivery levels:

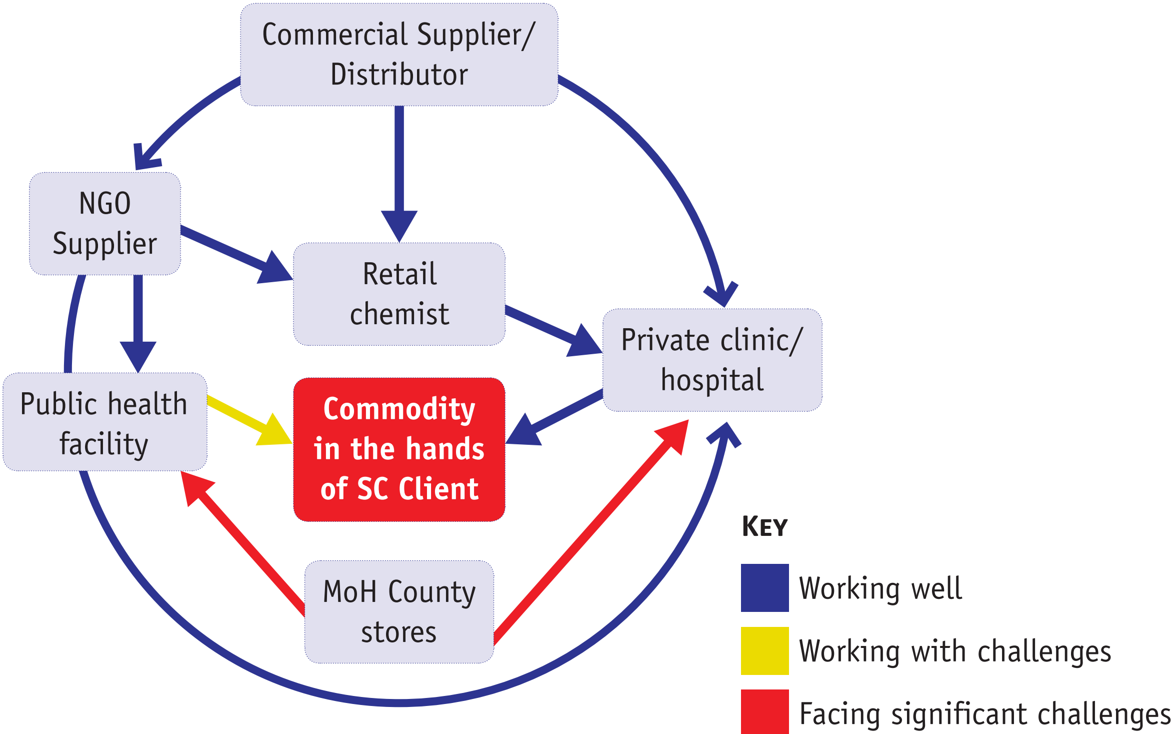
> *"FP commodity supplies availability is a yes and no, the push system led to expiries, we have had stock outs here and there," FGD CHMT Participant.*

The strategy of the county in making SC services sustainable including reliable commodity supplies is to integrate it into regular county plans rather than running parallel programs.

"Integration of self-care activities in on-going activities would be the best way to sustain it. Making SC activities part of budgeted county plans will improve ownership and sustainability" FGD CHMT participant.

CHPs are not currently used as a channel for SC commodity supplies other than condom distribution. This could be because the county is yet to fully rollout SC as part of their mandate.

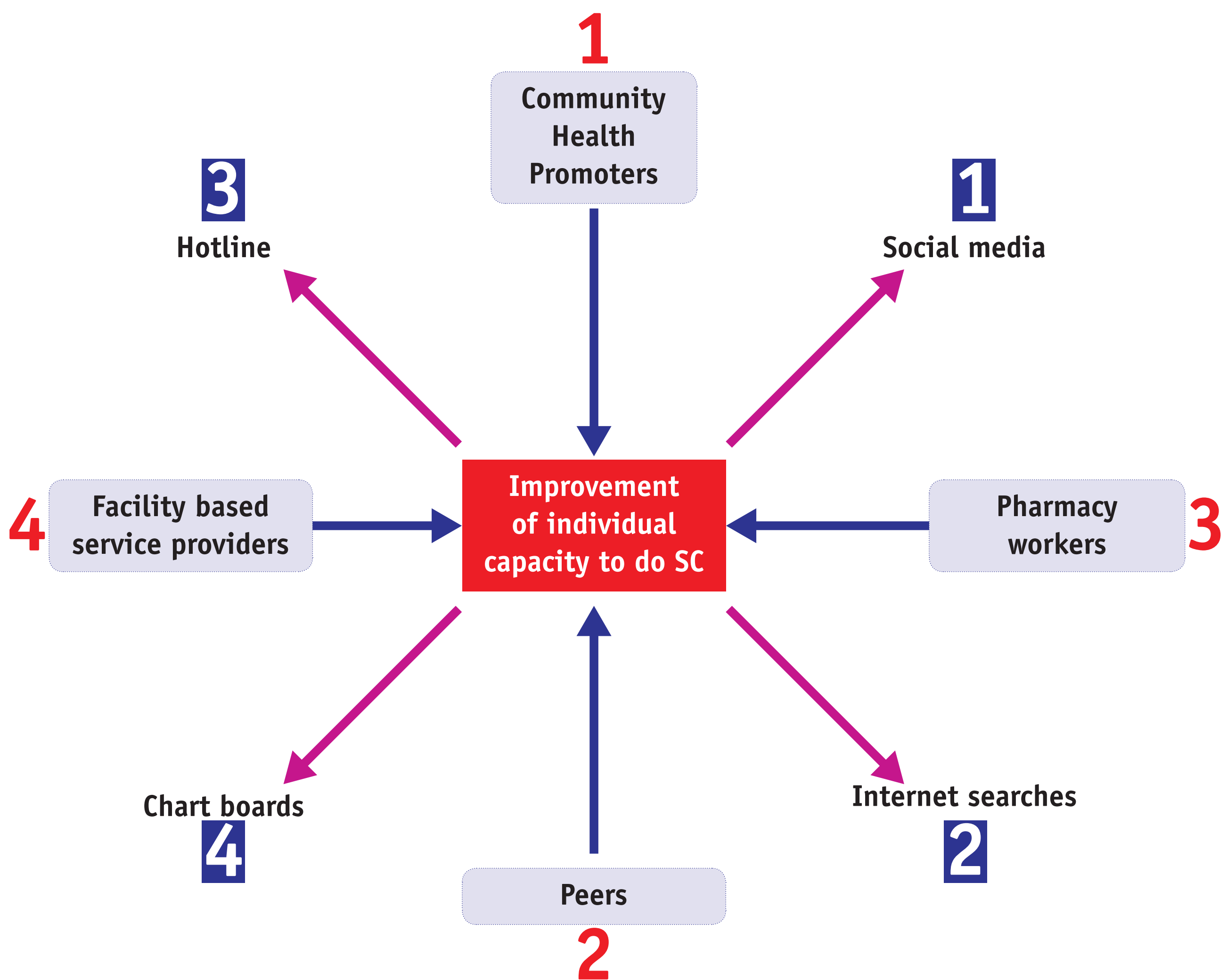
Fig. 2: Current Map of Commodity Supply Chain for Self-care



vii. Effectiveness of channels for promoting self-care

The success of self-care can be measured by self-driven service uptake by community members. Community members however only utilize services if they are self-aware and with adequate knowledge and ability to self-diagnose, treat and/or refer. Sensitization and capacity development of community members are therefore key to the success of self-care.
The following diagram summarizes the sources of information, sensitization and capacity building for community members that the evaluation team found in Bungoma:

Fig. 3: Sources of Improvement of Individual Capacities to do Self-care



Key

- Extrinsic sources of information to the individual
- Community member's own initiative to seek information

The sources of capacity development are either initiated and/or delivered by extrinsic sources targeting community members or are intrinsic in which an individual takes initiative to proactively search for information and build their knowledge.

Extrinsic Sources

The evaluation team found four sources of extrinsic information with their effectiveness being rated as shown in figure 3 above.

The source most mentioned as influencing health actions/behavior was taken to be the most effective. Education by CHPs was the most mentioned followed by peer influence; information by pharmacy workers and finally information by clinic and hospital-based service providers.

The effectiveness of CHPs arises from the fact that they are the first to introduce community members to new health initiatives and answer one on one any questions community members may have. They do this when they visit households. After this initial contact, members of the community seek a service after which they start educating and influencing their peers by describing their personal experiences, making peer influence the second most important source of capacity building.

"Initially referrals for services is done by the CHPs but thereafter the community members teach each other, and the community members start seeking services on their own after peer referral. They know where services are provided, they even know the cost of the service," KII participant.

Two concerns were however raised concerning the CHPs: they are in a hurry when they visit households because of the number of households they have to cover. Secondly, most of them are older and young people find it difficult to open up to them, especially because they are members of the community and the young people fear that they could report whatever is discussed back to their parents.

"The CHPs do not talk to young people, they do not understand our issues; they just blame us, we try to avoid the," Youth FGD participant.
Pharmacies are easily accessible, and clients walk in and ask questions, for themselves and for their friends. This is as opposed to clinics and hospitals which have a bureaucratic procedure before one gets to talk to a service provider.

Intrinsic Sources

The study team found social media – Facebook, WhatsApp, Instagram, etc. to be in widespread use especially by the young people making it the leading intrinsic source of information. Those who have obtained information from external sources sometimes share it in social media. Information that may not be clear is researched further by searching the internet. Chart boards and hotlines, both initiatives by SC implementers, are yet to fully pick up and currently rank last as sources of information.

"We have never heard of the hotline. We do not know what it is but it sounds like something that can help people." FGD CHP participant.

The evaluation team identified at least 3 hotlines in the county. They are promoted in various ways including hotline cards, mentions and demos during community meetings, and in pharmacies as part of the information package. Despite the promotion of the hotlines, very few calls come through – zero to five in a week and sometimes the calls are not in relation to health and self-care.

"There is a housemaid who called asking for help because she had not been paid by her employer for three months. There is an assumption that it is just a government number," FGD CHMT participant.

Reasons given for low use of the tollfree numbers include the number being too long and hard to remember and possibly the fact that it has not been fully integrated as a normal way of passing health information and guidance in communities.

"The tollfree number is long and hard to remember. Making it shorter would help," FGD CHMT participant.

Participants suggested that the tollfree service could be revamped by having a ringing tone that explains what it is. It could also send mass messages on health. Further, it could be linked to people in sub-counties to follow up with cases on the ground instead of the person at a central place receiving calls being tasked to respond to the patient's concerns. Post-call evaluation by the client would be good. After the service clients should be able to give feedback. It could help to link the government tollfree line to the RHNK call centre so that it benefits from the infrastructure being set up.

The main problem with the chat board is that it requires one to have bundles. The youth, who find it acceptable, complained that they lack bundles.

viii. Gender and SC Implementation

The evaluation team found that there are gender concerns in the way SC is being implemented. There was a concern by the participants that interventions seem to be focused on the girls and leave out the boys.

"The guidelines are quite focused on the girl child. Boys also need self-care," FGM CHMT participant.

In fact, participants were concerned that men are the cause of SRH problems in their community and should therefore be better targeted:

> *"Men are taking advantage of young girls, they provide incentives to the girls and get sex in return, and when they are taken to court they pay their way out," FGD CHMT participants.*

"The women don't come with the men when they are asking for abortion. They say the men have abandoned them," KII Pharmacy tech.

It was agreed that interventions must henceforth target both men and women.

"Leaving out men in interventions has not helped, girls are targeted but the perpetrators are the men. We need to include men in our interventions," FGD CHMT participants.
The reason for involving men is so that they need to be similarly responsible for SRH. They need to have capacity to appreciate the efforts women make to improve SRH.

"When it comes to FP acceptance and preventing unwanted pregnancies men are a big problem. There are many who just hit and run." FGD CHP participant.

"And they like young girls, the old men that is, they get renewed by having unprotected sex with the young girls," FGD CHP participant.

It was reported that men even fear HIV testing, taking ARVs and sharing their SRH problems eve with close relatives.

"My own brother who is HIV positive has married four women and all have died because of HIV. He never tells them that he is positive, they get sick and die, sometimes after being diagnosed to be HIV positive in the antenatal clinic," Community FGD participant.

Men were reported to prefer unsafe sex, exposing women to unwanted pregnancy and infection. "Most men don't even want condoms, they even tear them open before sex start without your knowledge; they say you cannot eat a sweet which is wrapped," community FGD participant.

ix. Specific Service Outcomes

Abortion

It was reported that abortion is one of the SC services that has picked up quickly. Women buy testing kits from pharmacies and do self-testing for pregnancy. When a pregnancy is unwanted, women use knowledge that they have gained from CHPs and peers to take the next step.

"The women teach each other what to do. They refer each other to the providers. We also refer them to the doctors," FGD CHP participant.

A few use the hotlines and chat boards to further get guidance and referral.

Pharmacies and private clinics are the preferred service points by the women, with public health facilities yet to fully pick up.

"If you have a pregnancy you don't want you can abort, you can get the service in the pharmacy or a private clinic, not in the government hospital," Community FGD participant.

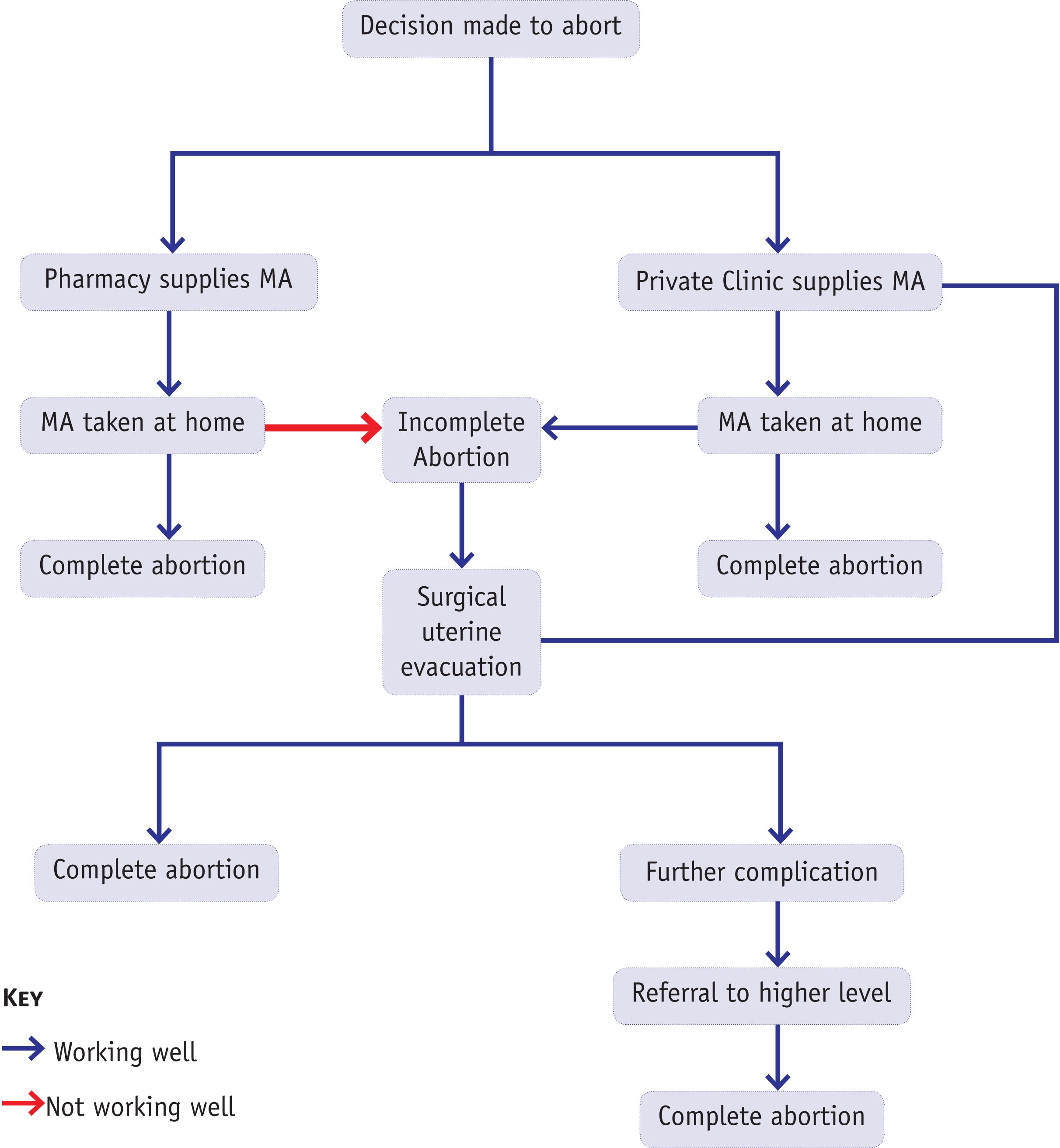
As such, service providers in private facilities have statistics that they report to NGOs that support them.

“I do a minimum of 5 abortions per month, mostly referred by CHPs,” FGD Service provider participant.

“I get many from Nena na Binti, I do at least 10 in a month,” FGD Service provider participant.

“Our abortion statistics are 50 to 112 per month in Bungoma,” KII participant.

Fig. 4: Abortion Care Pathway



Concerns raised by providers include quality of some MA drugs which they say sometimes fail to achieve desired results; occasional harassment from police; and a weak referral network between service providers in clinics and those in pharmacies.

"The problem we have with the pharmacies is that they do not examine patients. Patients sometimes lie about their gestation yet the pharmacy person will not know because they do not examine. Once they give the MA drugs things don't happen as expected and the patients come to us yet they have not even alerted us," FGD service provider participant.

Providers have developed solutions to the challenges:

- Extrinsic Involving lawyers when police come harassing them
- Extrinsic Calling for joint trainings between them and pharmacists to agree on how best to work together

Family Planning

FP services have been in the community for long and many community members are making decisions to use the services. The challenge is commodity availability which tends to limit access. The county government reported that this has been a challenge and that they are addressing it.

"Commodities are not there. We only have depo and condoms for a long time now. The pills got finished," FGD CHP participant.

Injectable FP was reported to be the most used. Injections are given in hospitals/clinics and pharmacies. There is no self-injection happening.

"That one for injecting yourself, that one I have never heard of!" Community FGD participant. CHMT members confirmed that at the county management level they were yet to introduce the subcutaneous DMPA.

"Sayana Press is yet to reach Bungoma County, we have not trained our service providers, we are talking to partners to help," FGD CHMT participant.

They are of the view that women would accept the method. Their main worry is that disposal of waste may be a challenge when many women start using it.

A number of private clinic/hospital and pharmacy based service providers are however providing Sayana Press. They prefer to give the injection themselves rather than training the women to do it at home.

"Sayana Press is a new product. Even the government itself doesn't have it. We inject them, we have not allowed them (women) to do it," FGD service provider participant.

CHPs that are in close contact with households are not yet trained and do not know Sayana Press.

"We only carry condoms along. We do not have other FP commodities. We have never heard of Sayana Press," FGD CHP participant.

HIV

HIV SC services are the least attended to currently. This may be because there is no HIV focused organization in the SC Core Group. As such, the evaluation team encountered a number of myths around HIV that point to the fact that little community education is happening.

"If you take a pain killer and you go testing HIV it will turn negative, I have seen it and most people do that to hide their HIV," Community FGD participant.

There is a belief that the free condoms distributed by the government are laced with disease. As such people prefer to buy the condoms but also feel ashamed doing it. People can go a long distance to buy a condom from people who do not know them.

Service providers said that SC trainings given to date cover abortion and FP and not HIV. They are therefore not sure what self-care services are there in the field of HIV for them to promote. Even with no program rollout on HIV SC, self-testing does happen. People mostly buy the kits from pharmacies. The saliva test is more preferred. Once in a while CHPs do the tests at community level but supply of kits remains a challenge.

"We are empowered to do the oral HIV test. We sometimes get the test kits and we do them but the supplies are not always available," FGD CHP participant.

"They do self-testing, especially in the evenings. They do it in the bars," FGD Community participant.

Currently pre-exposure prophylaxis happens in government health facilities only. The service is not available in pharmacies or private clinics.

Recommendations

1. A clarification on the definition of SC by all partners is important in ensuring that its objective is realized. Clarify the definition with the county before rollout to avoid discontent in future.

2. NGOs are moving ahead of the government in implementing aspects of the SC guidelines. This is a normal occurrence for controversial services such abortion. The government will take up lead once there is a wider acceptance of the service. Partners should not insist on the government showing leadership for such services but should insist on this for the less controversial ones like HIV, FP and other maternal health issues beyond abortion.

3. To have better coordination, the MoH should take stronger leadership for SC while allowing NGOs to spearhead the controversial services. An NGO partner should lead logistics as the MoH does the convening. Implementers should talk more to each other and co-implement activities where possible.

4. Turf wars could derail SC implementation. Implementing NGOs and the county need to create opportunities for the various cadres to interact and agree on their scopes of work for SC including how to cross-refer patients.

5. As SC implementation takes off, the MoH should find ways of capturing data which may include revising data collection tools, mandating cadres like pharmacy workers to report their data, and protecting providers who report abortion data.

6. The government should purchase and distribute RH commodities in a more consistent way. For the private sector-provider supply chain, some form of quality and price control should be put in place.

7. More needs to be done to get value out of the hotlines as currently set. Regular evaluation should be done to find out if the hotlines give value for money or if the time-tested methods of CHP and peer education should be the ones to be prioritized.

8. Proactively include men in SC interventions. They are currently left out.

9. Hire young CHPs to target young people with information and capacity building.

10. Re-evaluate the return on investment for hotlines compared to other more effective channels of information/capacity and re-direct investment to more impactful approaches.

11. Design programs that proactively target the boys and men with information and capacity building.

12. Train MA service providers together, especially pharmacy and hospital/clinic providers and spell out roles in patient care so as to improve collaboration and referral

13. Service providers, including those in pharmacies, need to be trained and encouraged to rollout DMPA self-injection as they seem to be stuck with doing the injection themselves.

14. Get a strong HIV implementing partner in the SCCG to push for implementation of HIV SC services.

APPENDIX KII and FGD Guide Questions

1. When did you first get to know about the self-care initiative?
   a) Training?
   b) Meeting?
   c) Social media?
   d) Others

2. What is your understanding of SC?
3. What is you view on the whole concept of SC?
4. What self-care committees or groups do you belong to?
5. How has communication around SC been generally done?
6. How effective is SC communication to:
   a) Partners
   b) Patients

7. How can communication on SC be improved?

8. How are SC initiatives by different partners coordinated?

9. How can coordination of partners implementing SC be made more effective in the county?

10. How is leadership for SC currently undertaken?

11. How can leadership for SC in the county be improved?

12. What SC initiatives have you been involved in?
    a) In policy and legislation
    b) In improving patient self-awareness/education
    c) In self-diagnosis
    d) In commodity supply
    e) In supporting self-treatment
    f) In referral
    g) Others

13. What outcomes have SC initiatives achieved for:
    a) Abortion
    b) Contraception

c) DMPA self-injection
d) Others

14. What is your view on toll-free calls approach in implementing SC?

15. What challenges has SC generally faced?

16. How can SC implementation be improved?

17. How can SC be made sustainable?

18. How can SC be integrated in the MoH routine service delivery?

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