

PRACTICE MAKES PERFECT: A HANDS-ON APPROACH TO IN-SERVICE FAMILY PLANNING TRAINING IN KENYA

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BACKGROUND

The health and economic benefits of family planning are widely recognized (UNFPA 2001), and the world has witnessed a steady rise in the use of modern contraceptive methods since the 1970s. In Kenya, modern contraceptive consumption among currently married women, which was just 7% in 1978 (Ogola and Adala 2004), rose to 53% by 2014 (KNBS and ICF Macro 2015). Despite these gains, the use of long-acting reversible contraception (LARC) has remained relatively low, with use of intrauterine devices (IUDs) at 3.4% and implants at 10%. LARC uptake is lower for rural women than urban women (0.9% vs. 4.7% for IUD and 4.4% vs. 12% for implants), and fertility differentials show that rural women give birth to more children (KNBS and ICF Macro 2015).

The 2010 Kenya Service Provision Assessment indicated that availability of LARC had broadened over time, with, for example, 55% of Kenyan family planning facilities offering IUDs in 2010 as compared with 36% in 2004 (Ogola and Adala 2004). This may be partially the result of a push by the Ministry of Health (MOH), through development partners supporting reproductive health services, to emphasize training of service providers on LARC, given that these methods offer a higher level of couple years of protection (CYP). In the context of the growing availability of LARC and the need to maintain high-quality services, it is important to regularly offer in-service training to family planning

providers. Training boosts providers' ability and confidence to manage complications and side effects, and gives health workers the knowledge and skills they need to ensure that clients have the widest possible contraceptive choices (Kinaro et al. 2015). Training may also help reduce provider biases toward LARC, which may impede some women—especially unmarried youth—from initiating contraception (Hamid and Stephenson 2006; Kinaro 2013; Kinaro et al. 2015).

The FUNZOKenya project, led by IntraHealth International and funded by the President's Emergency Plan for AIDS Relief (PEPFAR) through USAID, has worked to address skills gaps within Kenya's health workforce. The project supported the MOH by increasing access to high-quality and responsive in-service training that provides health workers with intensive, hands-on clinic-based instruction in service delivery, including family planning training focusing on LARC. To consider the possible impact of family planning in-service training on health workers' promotion and provision of LARC, FUNZOKenya conducted a study to examine uptake of IUDs and implants at facilities where providers had received training. This technical brief describes the study's results and shares some of the experiences of rural family planning providers who received LARC training.



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TRAINING APPROACH

The family planning in-service training, carried out in April 2014, focused on building the capacity and confidence of providers of LARC in counseling and insertion, with the aim of increasing client uptake of implants and IUDs. Previous to the intervention, health facilities were stocked with IUDs and implants, but health workers were not providing enough information about them for women to make informed choices.



Health worker counsels a client after inserting a contraceptive implant during one of the practical sessions of the training.

The five-day training used a standardized curriculum, developed by the MOH with support from USAID, which emphasizes acquisition of competencies and practical learning in clinic settings to support transfer of knowledge and practical skills to health workers. Unlike other forms of in-service training that are carried out in hotels and use dummy models to demonstrate and practice insertion procedures, trainees gained hands-on experience with real clients in clinic settings under the careful supervision of an experienced provider. The training also covered counseling, infection control, and record-keeping. Forty-one nurses and clinical officers from 33 facilities participated in the training. Participants were selected from rural health facilities in four counties with low LARC use that were USAID focus counties for FUNZOKenya-led training (Bomet, Kakamega, Kiambu, and Machakos).

METHODS

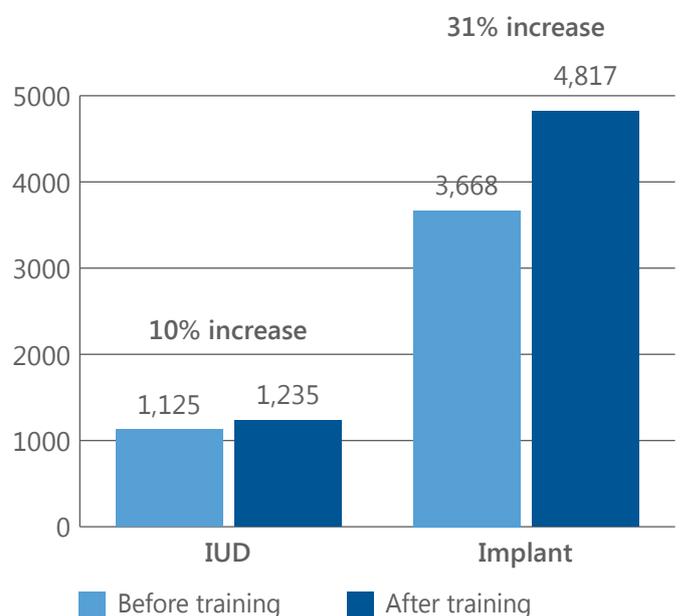
The project carried out a desk review to analyze secondary data on family planning clients' uptake of implants and IUDs in 33 facilities where health workers participating in the in-service training worked. The study team used data from iHRIS Train—a tool for tracking and managing health worker training activities that is part of IntraHealth's open source iHRIS human resources information systems software package (iHRIS n.d.)—to confirm the trainees' health facilities.

The study examined uptake of the two methods six months before and six months after the April 2014 training. The data were extracted from quarterly reports produced by the District Health Information System, version 2 (DHIS 2), used by the MOH to collate data from health facilities. Key variables included time period (six months before/after training), county, facility, contraceptive method provided, and whether a client visit was a new visit or a revisit.

FINDINGS

The data indicated that 1,235 clients accepted IUDs six months after the health workers received LARC in-service training, compared to 1,125 clients who had accepted IUDs six months before the training. This reflects an increase of 10% in IUD uptake (see Figure 2). The use of implants rose by a more substantial 31% between the two time periods, from 3,668 to 4,817 clients (Figure 1). Client revisits decreased by 8.3% after training, most likely because IUD and implant users require fewer follow-up clinic visits.

Figure 1: IUD and Implant Use Six Months Before and Six Months After LARC Training



A nurse working in a remote rural area who participated in the LARC in-service training described the disadvantages of the more limited method mix that was previously available:

“Before the training, we were only giving the injection and the pills. Unfortunately, the pill is highly technical to use and, this being a rural area where most people are illiterate, they cannot use them properly.”

The nurse works in a model health center located about 10 kilometers south of Mombasa Island in an area with poor road infrastructure. The main means of transport from the area to Mombasa Island is by taxi motorcycle and involves crossing on the congested Likoni ferry. Although more family planning options are available in Mombasa Island, most women who live in the small rural community are hesitant to make the long trip. The fact that the community’s health center can now offer a wider range of family planning methods, including LARC, has increased contraceptive uptake among the local women.

Jane Kinya, a nurse at one of the hospitals where the project conducted LARC training, stated:

“The training has helped us gain a lot of confidence on most of the procedures. As a nurse, you cannot recommend something you are not confident about. We have also been trained on counseling techniques and how to give the client the right information and answer all their questions.”

DISCUSSION

The hypothesis underlying the FUNZOKenya project’s shift in training approaches was that hands-on clinic-based training would have a positive impact on provider confidence and willingness to promote and insert long-acting reversible methods, which in turn could increase contraceptive choice and client uptake of LARC methods.

The project’s analysis of client records six months before and after training indicates that acceptance of implants, in fact, did increase dramatically, and there was also a modest increase in IUD acceptance. It is plausible that the training increased health workers’ confidence to the extent that they became more willing to recommend the two methods and less likely to refer women who asked for LARC to other facilities. Moreover, providers’ improved skills and competence may also have increased overall demand for modern contraceptives. Other studies have produced similar findings, indicating that



Mrs. Jane Kinya, a nurse, prepares to insert a contraceptive implant during a practical session with a real patient.

in-service training not only strengthens provider knowledge and skills but also directly influences clients’ health-seeking behavior for family planning services (Kinari et al. 2015; Rahaim and Ugaz 2013).

The adoption of long-acting methods of contraception offers advantages to providers and facilities (e.g., fewer client visits and reduced client load) as well as to clients (fewer recurrent costs and less travel time for revisits). However, further research is needed to understand what circumstances actually shape clients’ interest and willingness to adopt LARC over other contraceptive methods and whether reduction in client visits may be a contributing factor. Because this study relied solely on analysis of DHIS 2 data, it was not able to capture contextual information that would permit a deeper understanding of the factors shaping clients’ decision-making around method choice. This aspect would require client exit interviews as well as provider interviews to help better understand the phenomenon.

RECOMMENDATIONS

This study suggests that in-service training on LARC, which increases health worker skills to provide a wider range of family planning methods, can have a positive impact on contraceptive uptake. The findings point to:

- The wisdom of strengthening family planning in-service training so that it offers more supervised clinical practice in real-life settings, particularly

where the aim is to increase competence in providing LARC and thereby broaden the limited method mix that sometimes prevails.

- The particular importance of enhancing health workers' ability to provide long-acting reversible methods in rural areas where clients otherwise have to travel long distances to obtain the full array of family planning options and services.

More broadly, family planning in-service training should cover all family planning methods to ensure that providers have the clinical and counseling skills needed to offer the widest possible choice to clients.

CONCLUSION

In-service training clearly has the potential to build health workers' knowledge, skills, and ability to provide high-quality family planning services. The FUNZOKenya experience suggests that using real-life clinical settings to train providers to insert implants and IUDs may instill more provider confidence than abstract trainings that use dummies to demonstrate these procedures. Although the health facilities assessed in this study already were offering implants and IUDs before their providers attended the LARC training, the rapid increase in uptake of implants suggests that the in-service training may have served as a catalyst for broadening contraceptive choice and method mix.

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