

Kenyan Family Planning Providers Leverage Local Resources to Train Their Peers on Long-Acting and Permanent Methods

OVERVIEW

One in four married women in Kenya has an unmet need for family planning (KNBS & ICF Macro, 2010). While overall use of family planning increased modestly in Kenya during the 1990s and 2000s, use of the most effective contraceptive options—long-acting and permanent methods (LA/PMs)¹—declined from 10% in 1993 to 8% in 2009 (NCPD, CBS, & Macro International, 1994; KNBS & ICF Macro, 2010). LA/PMs are not only highly effective at preventing unintended pregnancy; they are also safe, cost-effective, and convenient for clients. In spite of the advantages of LA/PMs, their share of the modern method mix in Kenya decreased from 36% in 1993 (NCPD, CBS, & Macro International, 1994) to 21% in 2008–2009 (KNBS & ICF Macro, 2010), due to shifting priorities.

In response to the need for family planning, the Kenyan Ministry of Public Health’s Division of Reproductive Health (DRH) developed a strategy for increasing the uptake of LA/PMs in 2008. The strategy’s overarching goals were to establish a sustainable family planning program offering a balanced mix of short-acting, long-acting, and permanent methods. In recognition of the importance of holistic programming, the strategy is centered on five themes: capacity building, demand creation, contraceptive security, public-private partnerships, and sustainability (DRH, 2008).

The DRH sought to reinvigorate the program by building additional capacity among providers, as well as its own technical capacity at the central level to support provinces in providing a broad method mix. The DRH called upon the RESPOND Project (which is funded by the U.S. Agency for International Development [USAID]) to support these capacity-building efforts, beginning in the Nyanza and Rift Valley provinces, where unmet need for family planning is highest. Almost one-third of women in Nyanza (32%) and Rift Valley (31%) have an unmet need to space or limit births (KNBS & ICF Macro, 2010). With technical assistance from RESPOND, the DRH piloted an innovative approach

¹ Hormonal implants and the intrauterine device (IUD) are long-acting methods; male and female sterilization are permanent methods.

LEVERAGING LOCAL RESOURCES

“It shows that it’s sustainable, it doesn’t require a lot of resources, and at the end of the day, they were proud of themselves.”

—A master trainer, explaining the importance of leveraging local resources for cascade training workshops

designed to quickly and sustainably increase the number of providers prepared to offer LA/PMs, while fostering ownership and sustainability by leveraging local resources for training.

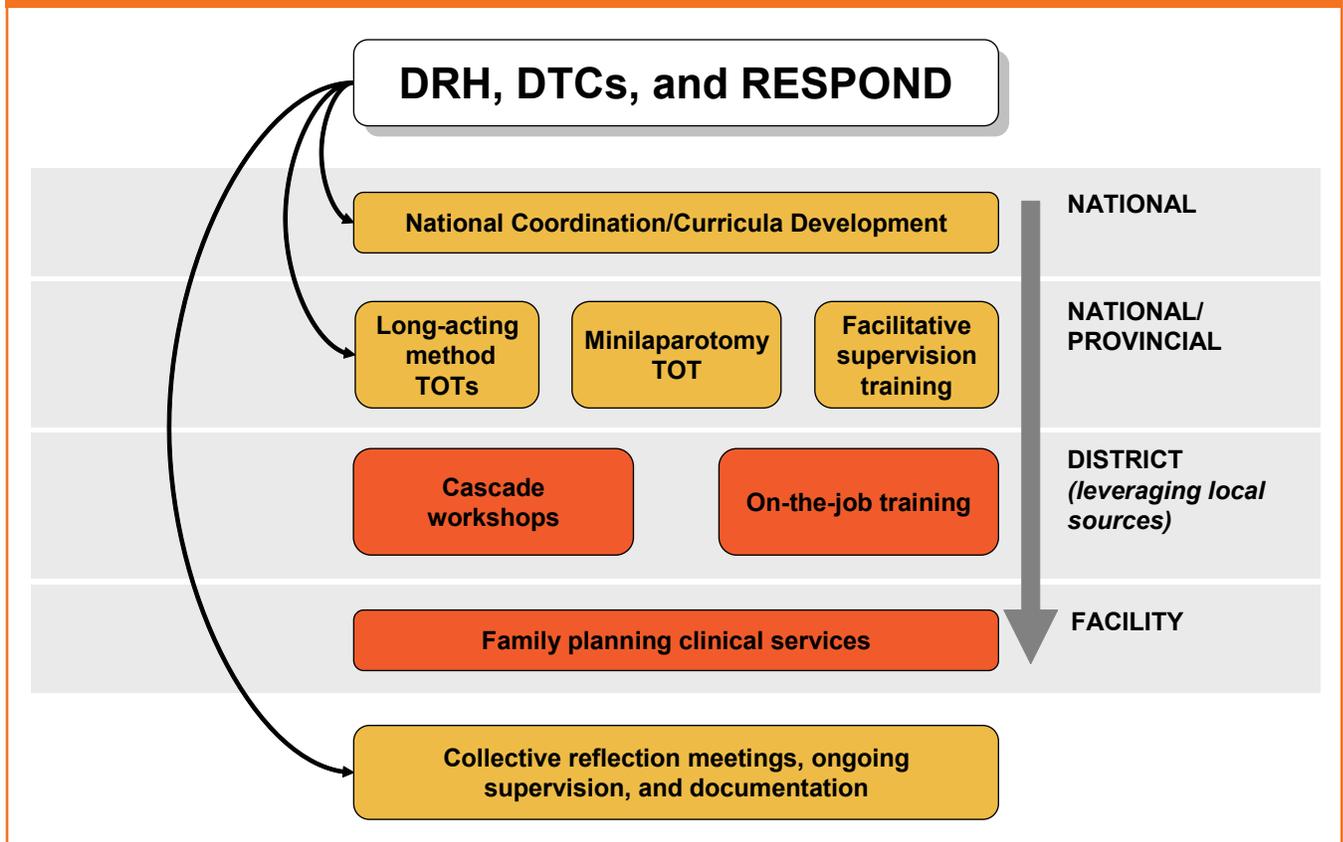
SUSTAINABLE CASCADE TRAINING APPROACH

Together with the DRH, RESPOND initiated a cascade training approach that could continue long after the end of support from RESPOND. First, RESPOND assisted the DRH to select an experienced team of national- and provincial-level master trainers from the DRH and government-run

decentralized training centers (DTCs). RESPOND international trainers then worked with the master trainers to train a subset of the doctors, nurses, and clinical officers who provide LA/PMs to serve as new, district-level LA/PM trainers. Then, under the supervision of the master trainers, the new trainers trained other doctors, nurses, and clinical officers in their districts to offer LA/PMs.

The new trainers **leveraged a variety of local resources**. For example, hospitals and DTCs contributed venues, anatomical models, and books. The DRH provided medical equipment, instruments, contraceptives, and expendable supplies and offered free LA/PM services to clients during the training. To ensure a good caseload for training, community health workers mobilized potential clients. In some cases, new trainers applied for funding from other organizations to cover workshop transportation and accommodation costs. In other cases, recognizing the value of the training and certification, health facilities or participants themselves paid their way to the training.

FIGURE 1. SUSTAINABLE CASCADE TRAINING APPROACH



A nurse in the Rift Valley explained that she financed her own participation because she knew that the training would make her a more marketable job candidate. A Rift Valley hospital administrator said that the training was a smart investment for the hospital because it would lead to additional revenue from LA/PM services.

Figure 1 illustrates the cascade training approach, distinguishing the activities that the DRH, DTCs, and RESPOND master trainers led (in yellow) from those that the new trainers and providers led themselves (in red).

Before initiating any training programs, the DRH and RESPOND brought together partner organizations to review existing LA/PM curricula and to develop a unified training package. The materials they developed included a program for **trainings of trainers (TOTs)**, as well as downstream cascade trainings. The TOT program covered two key topic areas: 1) standardization of clinical skills for LA/PM provision; and 2) standardization of training skills. The selection criteria specified that participants should be health service providers with experience in LA/PM provision and the potential to be effective trainers.

The DRH piloted the curriculum in a national-level TOT on LA/PMs in June 2010. Based on the pilot experience, the DRH and RESPOND revised the LA/PM training package, splitting it into a one-week course on long-acting methods, a two-week course on minilaparotomy for female sterilization, and a three-day course on no-scalpel vasectomy for male sterilization. Separating the training programs by method improved efficiency because the cadres of providers who offer long-acting methods differ from those who offer permanent methods.

In November 2010, the DRH, DTCs, and RESPOND collaborated to conduct two TOTs on long-acting methods. In January and February



A trainer in training standardizes her IUD insertion skills on a pelvic model in the skills lab set up at the TOT site.

From left to right: Lilian Sigei (master trainer from Nakuru DTC), TOT participant Everlyne Koske, and TOT participant Leah Waweru

2011, the DRH, DTCs, and RESPOND conducted a TOT on female sterilization for doctor-nurse pairs. The role of RESPOND was to support the local trainers and provide technical assistance and quality assurance, with the view of also handing these roles to local master trainers in the future. During the TOTs, providers practiced facilitating lessons and coaching each other on LA/PM service provision. On the last day, participant teams developed action plans outlining their plans to conduct cascade training through workshops and on-the-job training.

With technical assistance and oversight from the refreshed master trainers, the new trainers used local resources to organize and facilitate five **cascade training workshops** in long-acting methods between January and May 2011. The cascade training program was designed for family planning providers with little or no prior experience in providing long-acting methods. Cascade training included classroom instruction and supervised practice on anatomical models, followed by supervised practice on clients, with clients' informed and voluntary consent. The DRH master trainers awarded certificates in training and in long-acting

methods to TOT and cascade training participants who demonstrated competency at the end of training. Participants who did not earn certification during training workshops made plans to continue to refine their skills under supervision. When ready, they called the DRH or DTC master trainers to test them for certification. In addition, new trainers who successfully led a cascade training earned certification as LA/PM trainers.

Another avenue that new trainers used to transfer LA/PM skills was **on-the-job training (OJT)**. Trainers trained colleagues at their own facilities or periodically visited lower-level facilities to train providers. The advantages of OJT over cascade workshops are low cost and convenience. OJT is a common training approach in Kenya and is often the only option, due to limitations in funding and the availability of trainers. However, it has disadvantages, such as the lack of anatomical models for practice and the lack of supervision by master trainers. And while the curriculum for cascade workshops was standardized, OJT took on a number of variations, as the new trainers used the workshop training manual in a nonworkshop setting.

To support the quality of LA/PM service provision, the DRH, DTCs, and RESPOND conducted a training on **facilitative supervision** with a focus on LA/PMs in February 2011. The facilitative supervision approach, which was developed by EngenderHealth, emphasizes mentoring, joint problem solving, and two-way communication between the supervisor and supervisee. Participants included provincial reproductive health coordinators, some of the new and master trainers, and others who have supervisory roles. Changes in the knowledge of facilitative supervision trainees were apparent: Their average score on the facilitative supervision test increased from 47% before the training to 89% after the training.

Five months after the TOTs in long-acting methods, the DRH organized **collective reflection meetings** for new trainers. These meetings gave trainers an opportunity to share their accomplishments and challenges and to advise each other.

IMPROVEMENTS IN CAPACITY TO OFFER LA/PMS

From June 2010 through May 2011, the master trainers trained a total of 72 district-level trainers: 43 in long-acting methods, 13 in minilaparotomy, and 16 in both long-acting methods and minilaparotomy. At the end of the TOT, all of the new trainers in long-acting methods and 54% of those in minilaparotomy earned certification in LA/PMs. By May 2011, 36% of the new trainers had led a cascade training workshop in long-acting methods, earning them certification in state-of-the-art training practices. Over the course of the year, **new trainers trained at least 156 other providers**—roughly half through cascade workshops and half through OJT. Of the 75 providers trained in cascade workshops, 92% earned certification in long-acting methods. While none of the OJT trainees had an opportunity to take the competency-based certification assessment by May 2011 (when these data were collected), DRH master trainers plan to give them the test in the next year. The number of providers trained in LA/PMs is expected to continue rising, now that the new trainers have LA/PM training skills and experience with mobilizing local resources for trainings. Figure 2 presents the numbers of providers trained during the year, by type of training.

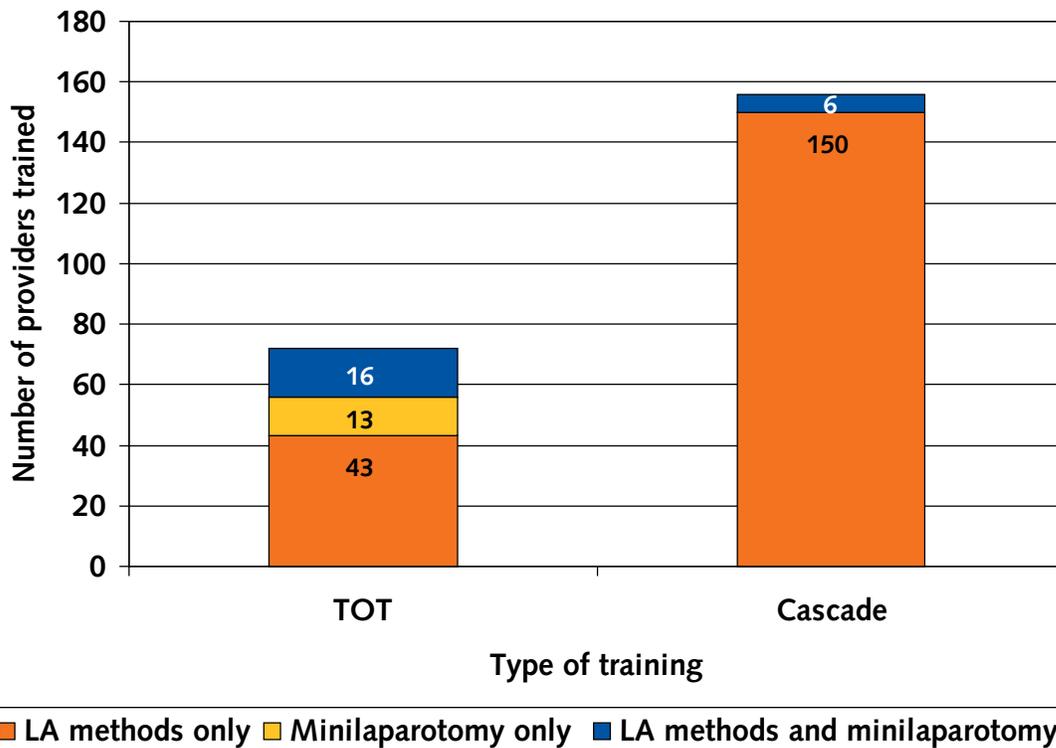
As a result of cascade training, a broader mix of family planning methods, including long-acting methods, became available at some facilities that had never provided them before: Between June 2010 and May 2011, 13 facilities provided implants and five facilities provided the IUD for the first time. A cascade workshop trainee commented, “When the clients used to come and I couldn’t offer the method they wanted, I felt bad, but now I can offer them.” Many facilities once offered long-acting methods only on days when they received

INCREASED SERVICE AVAILABILITY

“We are proud to say that all our RH staff can provide [long-acting methods] now with no problem. We have reduced the number coming for Depo [Provera], which saves us time.”

—A participant in OJT for long-acting methods

FIGURE 2. NUMBERS OF SERVICE PROVIDERS TRAINED, JUNE 2010–MAY 2011



outreach from partner organizations. Now, at least two of these facilities—Lumumba Health Centre and Kisumu East District Hospital—not only offer long-acting methods five days a week, but they also conduct regular outreach visits themselves.

To monitor LA/PM service quality, the master trainers followed up with a sample of six new long-acting method trainers and 42 cascade trainees. Master trainers reported that all six new trainers performed all critical steps of long-acting method provision correctly. Of the 42 cascade trainees who received follow-up supervision by master trainers, all but one performed all critical steps correctly. The master trainers also followed up with two minilaparotomy trainers, both of whom performed all critical steps correctly. In interviews, several trainers reported that, although they had been providing LA/PMs for many years, the TOT significantly improved the quality of the services they offer. A nurse in Nyanza said she learned some infection prevention practices for the first time in the TOT. A nurse in Rift Valley said, “Before the TOT, I was reluctant to do [the IUD].

Now, I’m very comfortable.” A Rift Valley surgeon reflected on major improvements in the quality of female sterilization he provides, as well as in how he teaches the method.

IMPROVED QUALITY

“The way I used to do it was wrong... and I used to teach my interns the wrong way too. The TOT did a lot to help. It made a very good impact.... I used to give the wrong dosage of local anesthesia. The patient’s pain management wasn’t right, so the patients were always jumping, jumping, and making life difficult for me as a surgeon. Sometimes I would sedate the patient, but that makes life much more difficult because they can’t follow your instructions. I also used to use my fingers rather than the tubal hook, so you can imagine how long it took. It used to take up to an hour. Now, it takes me 15 minutes.”

—A surgeon in Rift Valley who had been providing female sterilization for three years before participating in the TOT

Integration of LA/PMs into other reproductive health services featured heavily in the new trainers' action plans. Through cascade workshops and OJT, many new trainers succeeded in improving integration or LA/PM referrals within their facilities. For example, a team of three trainers from the Provincial General Hospital in Rift Valley led a cascade training workshop at their hospital in January 2011. They trained 14 nurses from the HIV/AIDS Comprehensive Care Center, the Youth Friendly Center, the Maternity, and the Gynecological Ward; all are well-positioned to discuss family planning with clients seeking other reproductive health services and, in some cases, offer family planning on-site. Trainees said that before the cascade training, they had trouble counseling patients on long-acting methods. One explained, "The myths are quite many, but I'm much better able to clarify after the training." As a result of the training, she is also able to better help clients meet their reproductive intentions by offering a wider range of family planning methods herself, rather than referring them to a different provider. "It's better to give them the method right away," she said.

The DRH led this initiative and is committed to the LA/PM revitalization effort. RESPOND's technical assistance and support rebuilt the DRH's capacity to program, train, supervise, and monitor LA/PM services in Kenya. By working at multiple levels, the project also strengthened national, provincial, and district linkages for training in LA/PM service delivery. Due to project successes, a national LA/PM training package for in-service training is available to be scaled up throughout the country if the necessary resources are mobilized.

TRENDS IN LA/PM USE

The capacity-building approach described here was associated with substantial increases in the use of long-acting methods in cascade trainees' facilities. In May 2011, cascade trainees inserted 25 times more implants and seven times more IUDs than they had done in same month of the prior year. (There were too few cascade trainees in female sterilization to see changes in the use of female sterilization.) Overall trends in implant use are illustrated in Figure 3, and trends in IUD use are illustrated in Figure 4.

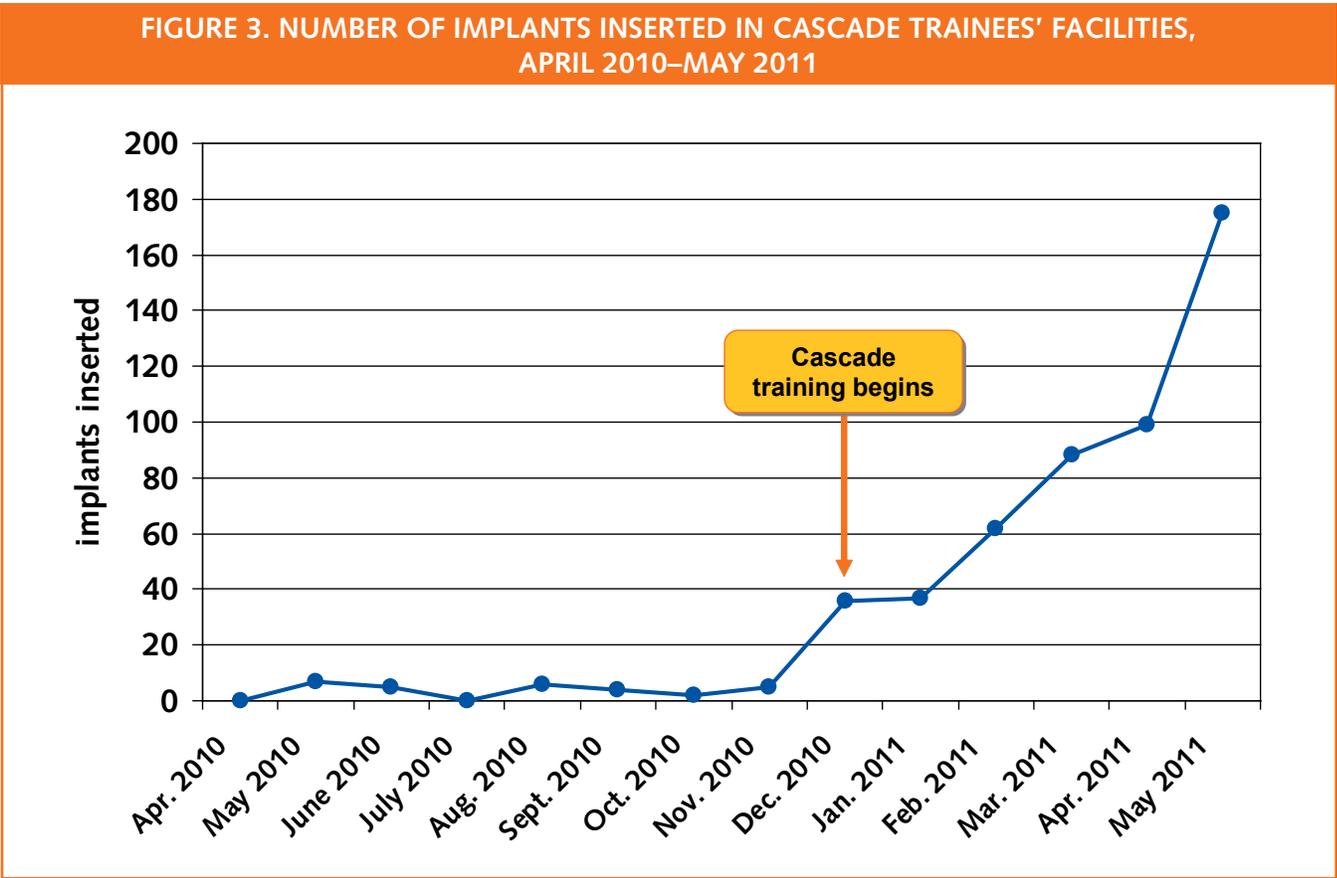
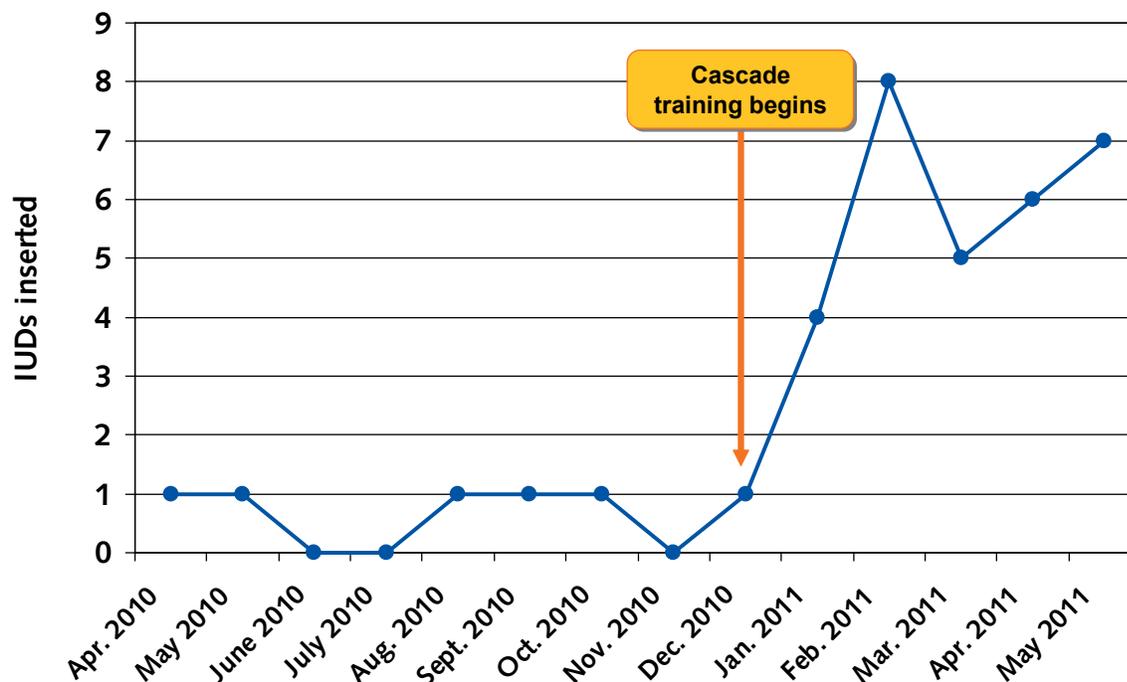


FIGURE 4. NUMBER OF IUDs INSERTED IN CASCADE TRAINEES' FACILITIES, APRIL 2010–MAY 2011



LESSONS AND RECOMMENDATIONS

- **Train trainers on how to plan and advocate for cascade training workshops.** Trainers often have little or no prior experience with budgeting and leveraging local resources for training. Consequently, several teams of trainers have not yet organized a cascade workshop. If the TOT builds their capacity to carry out these functions, cascade workshops may take place more frequently.
- **Strictly adhere to participant selection criteria.** While participants' evaluations of the trainings were overwhelmingly positive, some suggested that the trainings were too brief. In particular, participants said they could have used more time for questions, discussion, and clinical practice. The master trainers recommended more careful selection of participants to ensure that all have the knowledge, skills, and experience needed to keep up with the training. For example, while the selection criteria required cascade training participants to have prior experience with family planning provision, some did not. If there are less qualified trainees who want to dedicate themselves to family planning, perhaps reducing the number of trainees would allow for more questions, discussion, and clinical practice, since the numbers of anatomical models and clients are limited.
- **Retain key aspects of the approach:**
 - *Conduct trainings on long-acting methods separately from those on permanent methods.* As RESPOND learned when piloting the TOT curriculum in June 2010, trainings on long-acting methods should take place separately from trainings on permanent methods, since different cadres of providers offer these methods.
 - *Include client mobilization in action plans.* The approach worked best when training was connected with client mobilization. In Nyanza Province, so few clients chose the IUD that it was often difficult for the trainees to gain adequate practice. For example, districts could follow the EngenderHealth/ACQUIRE Project model from Kisii, Kenya, which successfully addressed demand for the IUD, as well as supply and the enabling environment (ACQUIRE Project, 2006).

- o *Offer facilitative supervision training as part of the training package.* Facilitative supervision training is an integral part of the approach, ensuring that supervision reinforces providers' new skills.
- o *Hold annual collective reflection meetings.* During these meetings, providers described their progress in implementing their action plans and talked through the challenges they faced. Providers came away from the meetings with renewed motivation to implement their action plans and with new ideas about how to resolve issues.
- **Standardize OJT.** The TOT program largely focused on preparing trainers to lead cascade training workshops. OJT is an important avenue for training as well, especially when workshops are not feasible. There is ample room to improve and formalize the OJT process for LA/PMs in Kenya, starting with the development of training manuals designed for OJT. Acknowledging this need, the DRH is now in the process of developing a manual on OJT. In the manual, the DRH should clarify the steps that new trainers need to take to borrow anatomical models for OJT and to summon master trainers to test and certify OJT trainees.
- **Take a holistic approach.** Building provider capacity is one part of a whole; it cannot stand alone. Due to a constellation of factors, including widespread myths and misconceptions about the IUD, few clients chose the IUD during trainings. As a result, some trainees did not become proficient in IUD insertion by the end of the training. Contra-

ceptive security posed a major challenge as well. Many facilities experienced implant stock-outs and others lacked the medical instruments and equipment needed for providing LA/PMs, curbing opportunities for providers to utilize their new skills. As EngenderHealth's Supply-Enabling Environment-Demand (SEED) model for family planning programming underscores (EngenderHealth, 2011), synergistic efforts in multiple areas are needed to revitalize LA/PMs. As the DRH addresses these and other lessons learned, efforts to improve all other essential components of the family planning program are needed.

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