

Implementing Best Practices: Improving Service Delivery in Nakuru, Nyeri and Homabay

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1.0 BACKGROUND

Implementing Best Practices, (IBP) is an initiative, which began in 1999 to enhance the ability of countries to identify and apply evidence-based and other demonstrated practices that improve the quality and delivery of reproductive health services. The World Health Organization (WHO) started the initiative in collaboration with other partner organizations and agencies including the US Agency for International Development (USAID), United Nations Population Fund (UNFPA), International Planned Parenthood Federation (IPPF) and 14 other global organizations.

The key to implementing the best practices initiative is to identify and facilitate synergies that can improve value for money spent in the effort to improve reproductive health services. Focus is placed on helping governments enhance programmes and maximize available resources through participation in a network operating at the country, regional and global levels; promoting harmonized approaches and sharing experiences, tools and lessons learned. The IBP initiative aims at meeting an important need through applying evidence-based standards, norms, guidelines and proven practices in collaboration with policy makers, programme managers and providers. In 2004, multiple countries came together in Uganda to discuss evidence based reproductive health best practices that could work well in their respective countries to reduce maternal mortality within 18 months. Kenya participated in this important meeting and pledged to reduce maternal mortality through improvements in family planning (FP) service delivery and availability.

The 2003 Kenya Demographic and Health Survey (KDHS) shows that maternal mortality remains high, estimated at 414 per 100,000 live births. Similarly, the data shows that fertility levels remain high in rural areas (5.4 children per woman) and unplanned pregnancies are common with 20% of the births being characterized as unplanned. Contraceptive use is estimated at 41% among married women and about a quarter of currently married women have an unmet family planning need. In addition, 38% of the women discontinue use within a twelve month period after adopting a contraceptive method. Against this backdrop, during the IBP meeting in June 2004, Kenya identified

various activities among them being the training of service providers to improve services in general and family planning in particular.

As part of the IBP partnership in Kenya, JHPIEGO/ ACCESS trained service providers in three districts namely: Nakuru, Nyeri and HomaBay. JHPIEGO, in collaboration with the Ministry of Health (MOH)/ Division of Reproductive Health (DRH), undertook a needs assessment in the three priority districts to establish the current levels of knowledge and practices among providers, supervisors and clients in relation to family planning and availability of contraceptives in selected facilities. Generally, the findings indicated that most facilities offer oral contraceptive pills (OCPs), condoms and injectables. Referrals for both Vasectomy and Tubal Ligation were common; 89% and 17% respectively. Over 70% of the clients interviewed indicated a preference to injectables. As much as they were aware of other methods including the IUCD (88%), 77% said they would not consider using it.

Following this assessment, the DRH and JHPIEGO/ ACCESS implemented interventions that sought to improve providers' and supervisors' knowledge and skills in order to increase uptake of contraceptive methods (method mix) and strengthen service provision. This report outlines the findings since the baseline assessment and the technical intervention, in relation to the following programme objectives.

1.1 PROJECT OBJECTIVES

- Increase FP uptake by 5% in selected facilities through the training of service providers;
- Improve service providers' skills through training in infection prevention, contraceptive technology updates, and family planning counseling courses;
- Strengthen service provision through training of supervisors and administrators on supervision.

2.0 DATA COLLECTION PROCESS AND KEY DEMOGRAPHIC FINDINGS

2.1 Data collection process

In collaboration with the Division of Reproductive Health (DRH), JHPIEGO/ACCESS updated the assessment tools to capture key information that was not captured during the baseline. The client contraceptive tool captured information from Jan-April 2005 and Jan-April 2006. The data was collected mid May 2006. Four tools were developed:

1. Facility Assessment tool
2. Service provider interview
3. Client Exit interview
4. Client contraceptive use

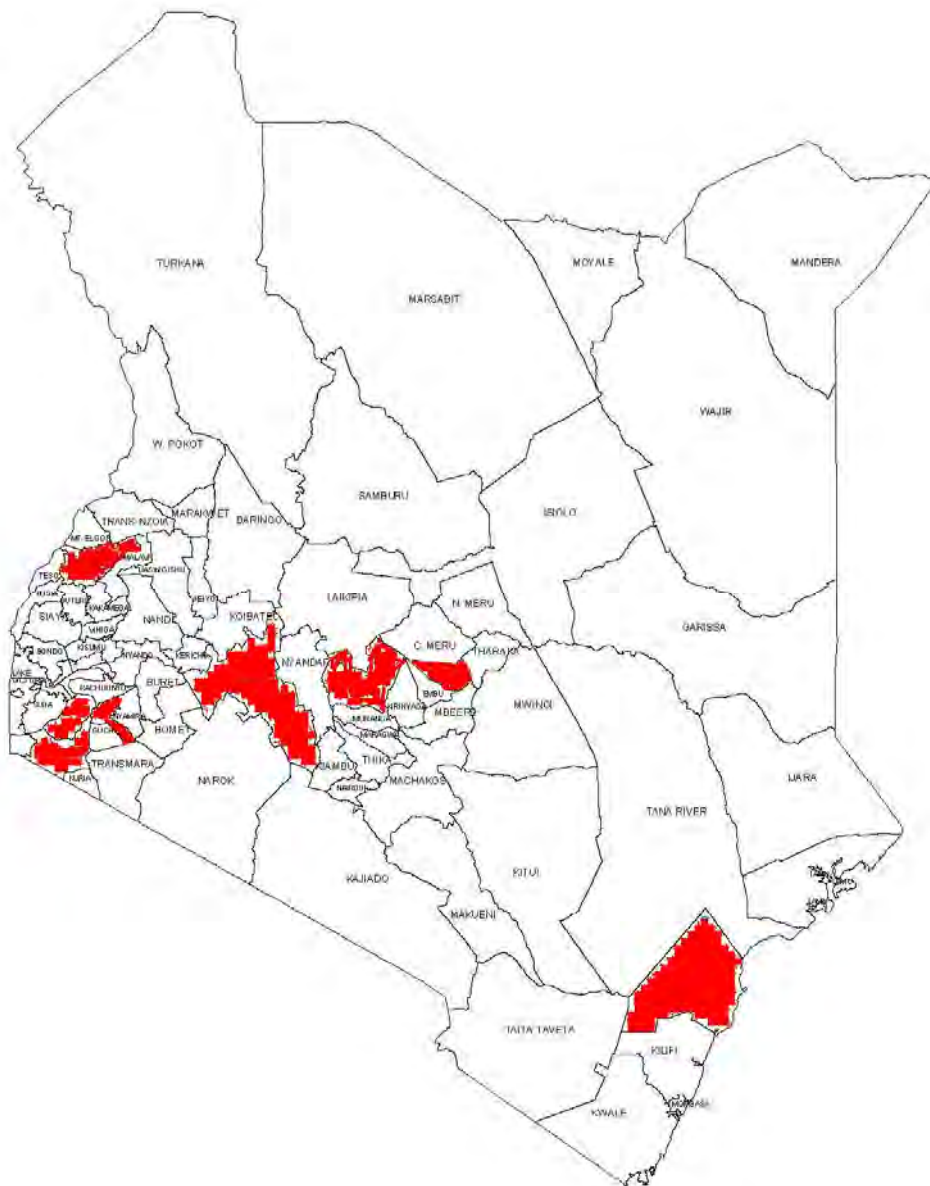
The target facilities were the same as those used in the baseline. The selection process, which was carried out during the initial advocacy meetings, was done together with the district health management teams (DHMTs) and key stakeholders within the district. Ten (10) facilities from each district were agreed upon. They included hospitals, health centers and dispensaries from both the public and private sector. In each of the districts, the number of facilities and individuals interviewed is shown in table 1 below.

Table 1: Interviews a numbers interviewed in study

Tool	HomaBay	Nakuru	Nyeri	Total No.
Facility Assessment tool	12	11	10	33
Service provider interview	13	20	20	53
Client Exit interview	49	51	81	181
Client contraceptive use-	9	10	10	29
Total				

A total of 33 health facilities were reached and 53 service providers interviewed. 181 client exit interviews were conducted. Below is a discussion on the key demographic findings as they relate to facilities and service providers. Figure 1 shows the three districts in which this activity was implemented, and those included in the Co Rapid Results Initiative.

Figure 1: Districts implementing IBP and those in the Rapid Results Initiative



2.2 Key demographic results

2.2.1 Facility information

Thirty-three health facilities were included in the sample. Of these, 13 were health centers, 11 hospitals and nine dispensaries. Figure 2 shows the type of health facility visited in each district. Most (27%) of the facilities visited were operated by the Government, one health center was operated through a non-government organization and three facilities (one hospital, one health center and one dispensary) were operated through the private sector.

2.2.1.1 Services offered in facility

Figure 2 Type of Health Facilities per District

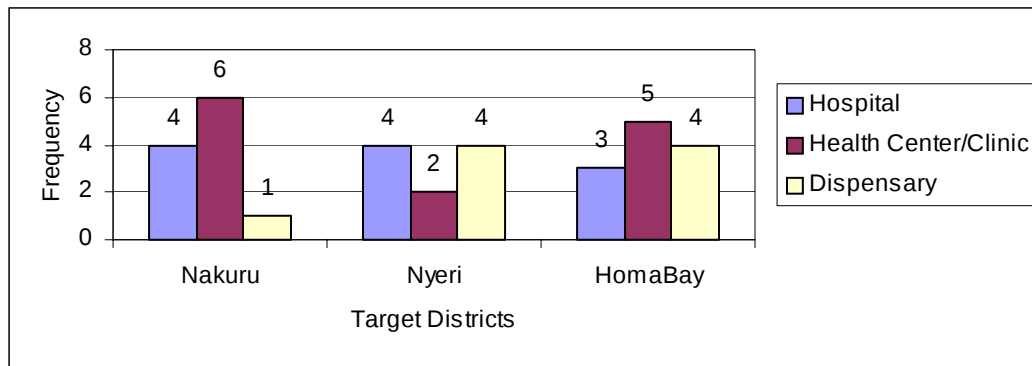
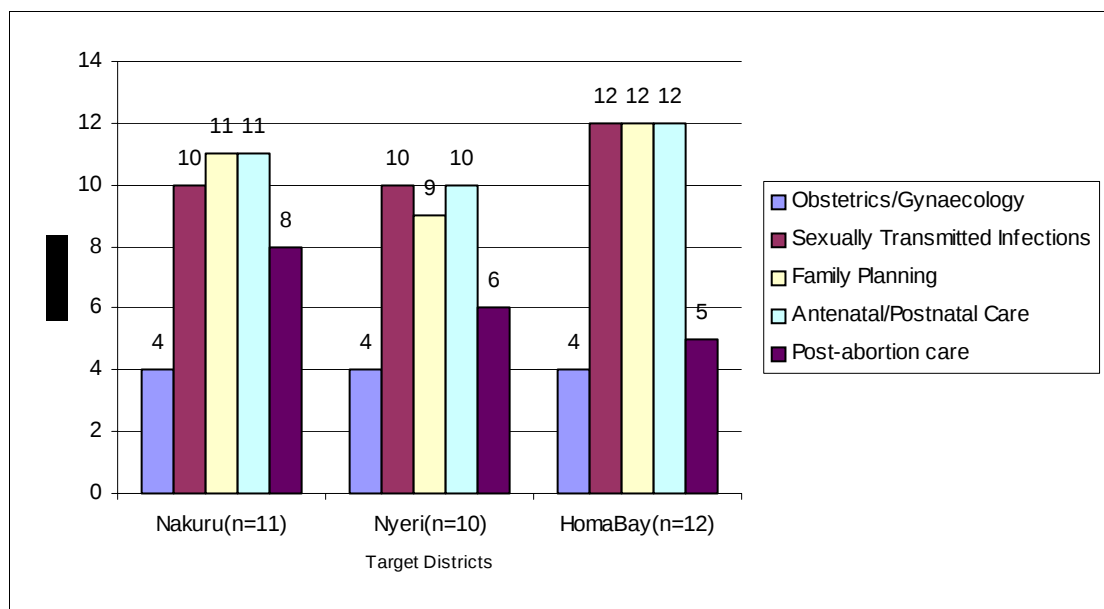


Figure 3 shows the types of services offered in the facilities visited. All the facilities are offering family planning, antenatal and postnatal care services. Obstetrics and Gynaecology services and post-abortion care services are offered, although to a much lesser extent. The larger health facilities tended to offer all the contraceptive services due to the developed infrastructure and trained medical doctors.

Figure 3 Services offered at sampled facilities



In Nyeri and Homabay districts, family planning services are said to be offered everyday in most health facilities. Nine facilities in Nakuru District offer family planning services on demand, while two facilities offer FP services on limited days/hours per week. Pills, condoms and injectables are the most common form of FP methods provided by all the facilities in Nakuru, Nyeri and Homabay. Vasectomy and natural family planning counselling are provided the least. Almost all the facilities in Nakuru (90%) were providing IUCD during this study. All facilities in Nyeri provided IUCD, while only 66% of the facilities in Homabay were providing IUCD. Additionally, the majority of health centres and hospitals have a trained clinician on staff trained to handle medical emergencies. However, none of the dispensaries had emergency transport mechanisms in place. An aspect, that needs to be addressed.

All facilities offered pills and condoms and nearly all offered injectables. The IUCD is more widely available in hospitals and health centers (see table 2 below). Very few facilities are offering Tubal Ligation, vasectomy, Jadelle and Norplant, although these are more prevalent in hospitals and health centers. This could be indicative of lack of provider skills at all levels to offer methods such as Tubal Ligation, vasectomy, Jadelle and Norplant. A Chi-Square test for relationship between availability of different types of

contraceptives and facility level showed that there is no significant relationship between contraceptive type and facility level (Chi-square=8.64, p-value=0.8536).

Table 2 Availability of FP Methods by Type of Facility

	Type Of Facility			Total(n=33)
	Hospital(n=11)	Health Center/Clinic(n=13)	Dispensary(n=9)	
Pills	11(100.0%)	13 (100.0%)	9 (100.0%)	33 (100.0%)
Condoms	11 (100.0%)	13 (100.0%)	9 (100.0%)	33 (100.0%)
Tubal Ligation	7 (63.6%)	5 (38.5%)	2 (22.2%)	14 (42.4%)
Vasectomy	2 (18.2%)	3 (23.1%)		5 (15.2%)
IUCD	10 (90.9%)	12 (92.3%)	6 (66.7%)	28 (84.8%)
Norplant/Implants	4 (36.4%)	4 (30.8%)		8 (24.2%)
Injectables	11 (100.0%)	12 (92.3%)	9 (100.0%)	32 (97.0%)
Jadelle	9 (81.8%)	9 (69.2%)	2 (22.2%)	20 (60.6%)
Natural FP	1 (9.1%)		1 (11.1%)	2 (6.1%)

2.3 Main demographic findings on service providers

Fifty-three service providers were interviewed from Nyeri, Nakuru, and HomaBay.

58.5% of the providers interviewed were female. Age of respondents varied, although a substantial number of providers were over 50 years of age. The majority of providers are registered nurses and midwives. A large proportion of providers have had a basic family planning certificate course. The number of years in service varied, although clearly providers from HomaBay have been working the longest (over 30 years). Table 3 below shows demographic information on service providers interviewed.

In Nyeri, 35% of service providers had been in service for between 10-19 years compared to 30% in Nakuru and 41% in Homabay. The Majority of the providers were registered nurses or midwives (53% in Nyeri; 47% in Nakuru and 63% Homabay). Many are over 50 years old.

Table 3 Demographic information on service providers

	Nyeri (n= 20) %	Nakuru (n=20) %	Homa bay (n= 13) %
Gender			
Male	65.0	20.0	38.5
Female	35.0	80.0	61.5
Age			
24yrs to 29yrs	15		8.3
30yrs to 34yrs	10	5.3	
35yrs to 39yrs	15	21.1	25
40yrs to 44yrs	15	10.5	33.3
45yrs to 49yrs	15	26.3	33.3
50yrs and above	30	36.8	
Qualification			
KRCHN	21.1	5.9	25
CO	5.3	35.3	12.5
ECN	21.1	11.8	
RN/M	52.6	47.1	62.5
Have basic FP	80	85	76.9
Number of years in service			
Less than 9 years	25	15	41.7
10-19 years	35	30	50
20-29 years	25	55	8.3
30-39 years	15		

3.0 KEY INTERVENTIONS AND RESULTS

3.1 Training on Family Planning Counselling, Contraceptive Technology Update (CTU)

Implementing Best Practices began in May 2005 in Kenya. The Ministry of Health – Division of Reproductive Health (MOH-DRH) spear-headed a team effort that included the IBP task force and training team. The training team developed a manual that consists of 4 major update topics- contraceptive technology updates (CTU), Infection Prevention (IP) Counselling and Facilitative supervision. JHPIEGO in collaboration with the MOH implemented this activity in Nyeri, Nakuru and Homabay.

In each of the districts JHPIEGO and the MOH conducted district planning meetings. Approximately **60** participants, drawn from the DHMT, DRHT&S teams, private institutions and NGOs, attended the advocacy and planning meetings in the 3 districts. A number of issues were deliberated on:-

- Inclusion of IBP in the district work-plan.
- Number of facilities to be selected for trainings and baseline.
- Selection criteria of service providers to attend trainings.

The three districts had not been supported with training over the last few years. Most service providers had last been trained in Family Planning (FP) more than 20 years ago with the last update on FP having been conducted 10 years ago.

In each of the three districts service providers were trained on contraceptive technology updates (CTU). The materials used were:

- The Essentials of Contraceptive Technology
- Implementing Best Practices Manual

- New Family Planning Guidelines
- Family Planning Wall Chart
- WHO Eligibility criteria

The updates included dissemination of the new FP guidelines, discussions on the WHO eligibility criteria. The focus of the updates was the application of the new FP guidelines and extensive discussions on the WHO eligibility criteria as applied to contraceptive use. Emphasis was laid on the latest technologies on all the contraceptive methods including integration of FP into HIV/AIDS. Additionally, providers' FP skills were reviewed and updated through classroom demonstrations and coaching. These were:-

- FP counseling skills.
- IUCD insertion and removal skills.
- Implant insertion and removal skills.
- Management of FP methods side effects.
- Dispelling rumors and misconceptions of FP methods (problem solving approach).

Discussions in plenary led to agreement about best practices and to dispel rumours and misconceptions on each method. These sessions were concluded with problem solving activities for each site. On the whole, knowledge gained by providers was good.

However, this varied according to the time frame each provider had had an update previously (that is if the last update had been 3 yrs ago or 20 yrs ago). Contrary to the statistics from the baseline that service providers felt they were deployed to areas that they could best practice their skills, assessments during the training indicated otherwise. Skills on methods like IUCD were weak and it became clear that most providers tended to use methods that were quicker and easier to dispense such pills and Depo Provera. Hence, service providers were trained on these methods through skills demonstration. Figure 4 shows service providers practicing IUCD insertion on a humanistic model during the training.

The training program covered two courses in Nakuru (52 participants), 2 courses in Nyeri (50 participants) and 2 courses in Homabay (51 participants). In total, **153** service providers were trained in the three districts. Providers were expected to update a

minimum of 5 others on the job. Each provider was given materials to assist them to sensitize other providers'. They were also given a reporting format to document on their progress. Work-plans were developed indicating the areas they identified as needing extra attention within their facilities in order to implement IBP. By the end of the activity, it was projected that a minimum of 755 providers will have been updated through the cascade approach.

Figure 4 Demonstration during the training on IUCD insertion



Evidence based on the training suggests that service providers were appreciative of the skills learned. The providers were trained on the use of methods such as Jadelle and the female condom. They were also given correct information on the IUCD. The WHO eligibility criteria were introduced with a view to reducing medical barriers in providing some methods such as Depo Provera, IUCD and the pill. The baseline study in the three districts had shown that service providers had beliefs related to provision of contraceptives to women with diabetes, hypertension, breastfeeding women and women with HIV/AIDS thus limiting access to contraceptives among this group of women. The usefulness of the training was expressed by one provider after information on the WHO eligibility criteria. The service provider commented:

“This training has been very useful. I feel that even the youth will benefit from the training we have received – in

terms of being able to access contraceptives.” He added: “This has been most useful to those of us who are clinical officers”.

Yet another service provider noted during support supervision:

“I now have an appreciation of the importance of counselling. This has been very useful in my work. Since I have up to date information on FP, I am now confident in discussing with my clients and I am able to adequately address their concerns”

3.1.1 Service provider practice after training

Training is essential in improving service provider skills and practice in family planning. In this follow up survey, all the service providers who had been trained and were interviewed indicated that they were using the skills learnt. Table 4 shows that the majority of providers have been able to apply new knowledge and skills acquired in trainings from the previous year. Most of the skills used were in infection prevention, basic family planning skills, and IUCD insertion/removal especially in Nyeri and Nakuru.

Table 4 Service provider use of knowledge and skills gained in training

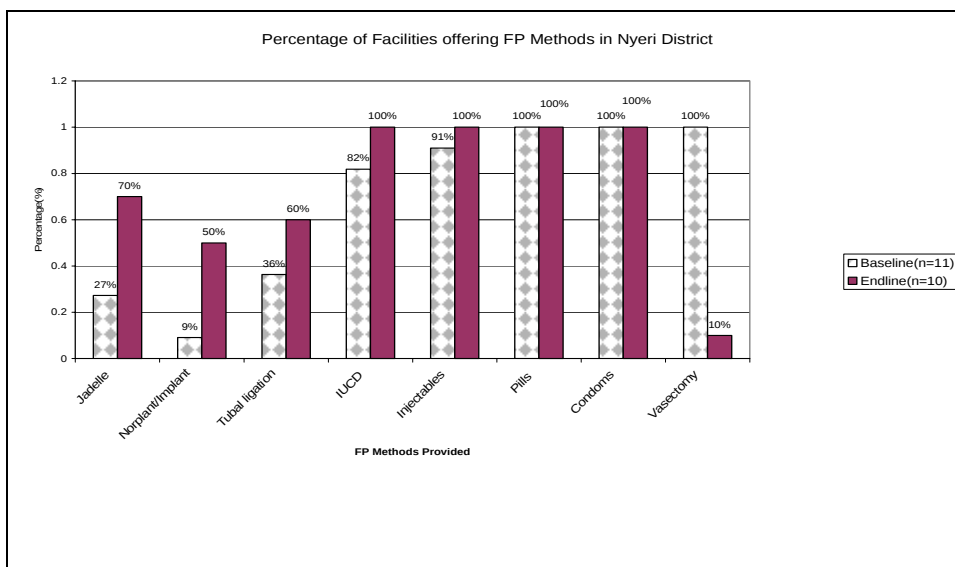
	Nyeri (n=7)	Nakuru (n=8)	HomaBay (n=10)	Total (n=25)
Infection prevention	5 (71.4%)	8 (100.0%)	9 (90.0%)	22 (88.0%)
Basic family planning skills	7 (100.0%)	8 (100.0%)	6 (60.0%)	21(84.0%)
IUCD insertion/removal	7 (100.0%)	8 (100.0%)	3 (30.0%)	18 (72.0%)
STI/HIV prevention counselling	5 (71.4%)	5 (62.5%)	6 (60.0%)	16 (64.0%)
STI/HIV diagnosis and treatment	3 (42.9%)	5 (62.5%)	6 (60.0%)	14 (56.0%)
Jadelle insertion/removal	3 (42.9%)	6 (75.0%)	3 (30.0%)	12 (48.0%)
How to involve men in RH	4 (57.1%)	2 (25.0%)	4 (40.0%)	10 (40.0%)
Norplant insertion/removal	1 (14.3%)	3 (37.5%)	2 (20.0%)	6 (24.0%)
Quality improvement (COPE)	3 (42.9%)	2 (25.0%)	1 (10.0%)	6 (24.0%)
Mini lap under local anesthesia	0 (0.0%)	3 (37.5%)	0 (0.0%)	3 (12.0%)
Vasectomy	0 (0.0%)	2 (25.0%)	0 (0.0%)	2 (8.0%)

Asked how the training received had been useful in their work, the providers explained that they were now able to:

- Offer their clients contraceptive options without relying on methods that are easy to dispense (hence contraceptive mix)
- Give methods confidently and adequately respond to client concerns
- Use of FP Guidelines as a reference thus improving on their work
- Practice appropriate infection prevention measures. Service providers noted that there was a greater appreciation for the need to reduce infections especially for both clients and providers.

As figure 5 below shows, the practice of service providers' improved in Nyeri after the training with service providers offering more contraceptive choice to their clients. This was also the case in Nakuru and Homa Bay. Earlier findings had indicated that service providers tend to offer contraceptive methods which are easier to dispense such as pills or injectables.

Figure 5 – Contraceptive practice before and after training in Nyeri



In Nyeri after the training and with the availability of Jadelle, its use increased by about 43%, while the use of Norplant increased by 41% and Tubal Ligation 24%. In regards to Tubal Ligation, it was explained that after the training, some service providers used a public forum to create awareness on the importance of this and other long term methods. This was followed by provision of Tubal Ligation services through a mobile clinic by Marie Stopes. Because of this awareness, women turned up for the service suggesting that there may be an unmet need among women for this, and other long term contraceptive methods.

In general, after the training there was an increase in the use of long term methods in all the districts (Table 5). For example, the use of IUCD increased by 17% while the use of Norplant increased by 45% and Jadelle by 23%. Knowledge and skills are important in service provider practice. As noted by KSPA 2004 there are methods that can be provided with minimal training (pills, injections, and condoms, as well as counseling on periodic abstinence) and those that require higher level of skill and a more developed infrastructure such as IUCD and implants.

Table 5 – Contraceptives offered before and after training (all districts)

	Baseline(n=31)	Endline(n=33)	%Change
Pills	100.0%	100.0%	0.0%
Condoms	100.0%	100.0%	0.0%
Tubal ligation	38.7%	42.4%	3.7%
IUCD	67.7%	84.8%	17.1%
Norplant/Implant	12.9%	57.6%	44.7%
Injectables	96.8%	75.8%	-21.0%
Jadelle	25.8%	48.5%	22.7%

3.1.2 Contraceptives Dispensed in the three districts before and after training

Prior to the IBP intervention and the targeted trainings, the number of contraceptives dispensed was estimated at 138,367. This increased substantially one year later to a 29% increase. The FP uptake reveals that the most popular contraceptive methods in the three

districts are male condoms, Depo Provera and OCPs. The methods less practiced were vasectomy and Tubal Ligation. Use of Depo Provera showed an increase while use of female condoms and vasectomy were declining. Review of the change in contraceptive uptake by district and under four categories barrier, short term, long term and permanent revealed inter and intra district differences (table 6).

Table 6 Total Percentage change in contraceptive use

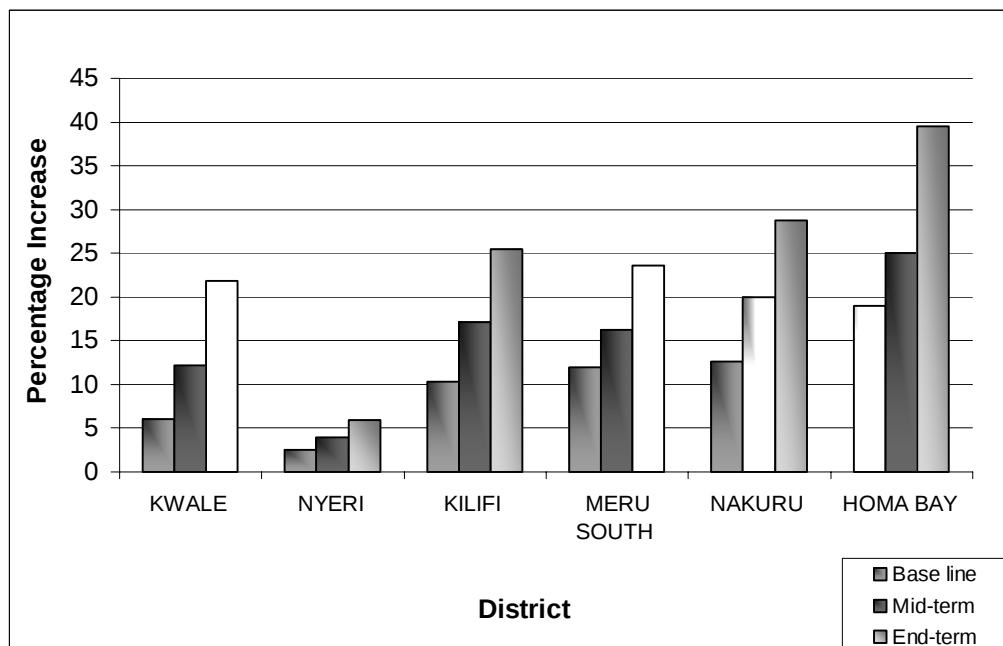
	Contraceptives	Year 2005	Year 2006	Total	Change	%Change
Long term	IUCD	520	525	1,045	5	0.96
	Jadelle	303	621	924	318	104.95
	Norplant	0	19	19	19	100.00
Permanent	Vasectomy	86	0	86	-86	-100.00
	Tubal Ligation	75	117	192	42	56.00
Barrier	Male condoms	109,365	147,237	256,602	37,872	34.63
	Female condoms	2,943	1,839	4,782	-1,104	-37.51
Short term	Depo Provera	16,020	19,419	35,439	3,399	21.22
	Oral pills	9,055	8,819	17,874	-236	-2.61

Data shows that in Homa Bay - uptake increased greatly for male condoms and moderately for other methods while in Nakuru, there is a mixed picture across all categories showing the increase in Depo Provera uptake is highest compared to other districts. Nyeri has the highest uptake for long term contraceptives replacing short term or barrier methods. There exists a significant association between the contraceptive type and dispensation by district (Chi-square=160.96, p-value=0.000<0.05 at 5% significance level) implying that some districts dispense certain types of contraceptives more than the others. It is important to establish the inter and intra district variations so that they can inform future trainings and the implementation of IBP.

One of the objectives in the implementation of IBP by JHPIEGO and MOH was to improve FP uptake by 5% in the three districts. After the training, JHPIEGO collaborated and supported the Ministry of Health in three of the six districts in a Ministry initiative dubbed the Rapid Results Initiative (RRI) to track the increase in Family planning (Figure 6). As the figure shows, the use of family planning increased by

22% in Homa Bay, 21% in Nakuru and 3% in Nyeri respectively. There is need to further review the low increase in Nyeri.

Figure 6 Increase use of contraceptive in Nyeri, Nakuru and Homabay



Support supervision revealed that service providers had not only gained knowledge on family planning, but the training had motivated them to be innovative in their work. During support supervision, one service provider narrated how the training and access to information had positively impacted on his facility. He explained:

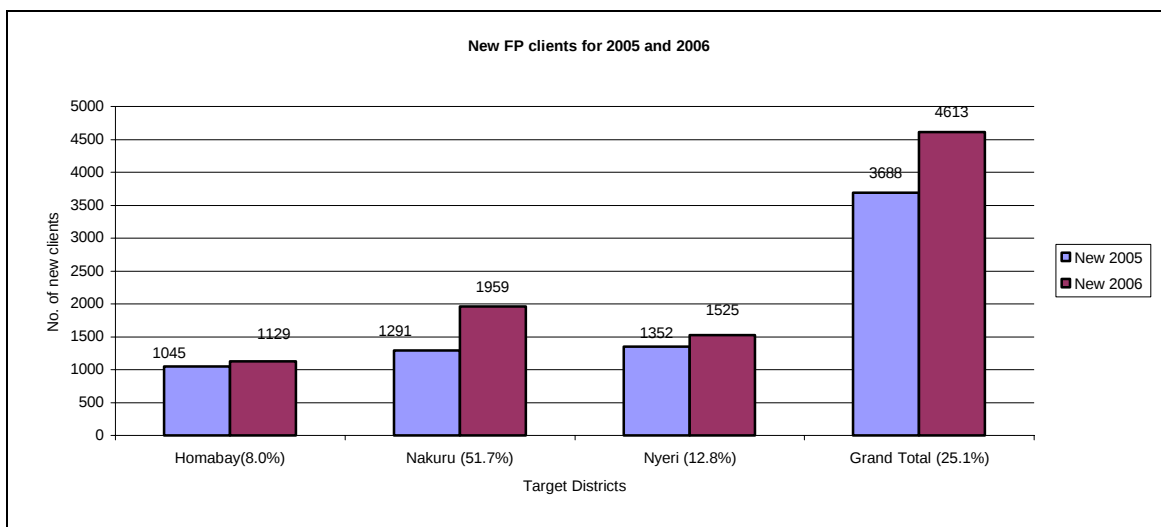
“ There used to be many cases of STIs in this facility. After the training, I took the initiative to share the materials in schools, other institutions and forums around this area and create awareness. Since then, the number of STIs has decreased in the facility and there is an increased demand for condoms. In the past, we always run out of drugs for treating STIs – this is not the case anymore!”

In yet another facility, the team undertaking support supervision found that the service provider who had been trained was not on duty. This provider had however oriented the other staff after the training. Indeed, the staff were very knowledgeable on FP and the facility had innovatively designated a specific room for FP which had not been the case before the training.

3.1.3 Contraceptive use among clients after service provider training

Client use of contraceptives is in part influenced by service provider practice. Clients who are satisfied with the services offered are more likely to make return visits and also to discuss the services offered with friends and other members of their social networks. Data in this follow up survey shows that the numbers of new clients increased by about 25% between 2005 and 2006 (Figure 7). Nakuru district had the highest number of new clients followed by Nyeri and Homabay districts. Although the numbers are still generally small, data analysis shows that there exists a significant association in the number of new clients by district in both the year 2005 and 2006 (Chi-square=48.48, p-value=0.000). Nakuru District had more new clients than any other district. Although the increase may not be solely attributed to the training of providers there is no doubt that this contributed to the increase.

Figure 7 Percentage change in clients in target districts

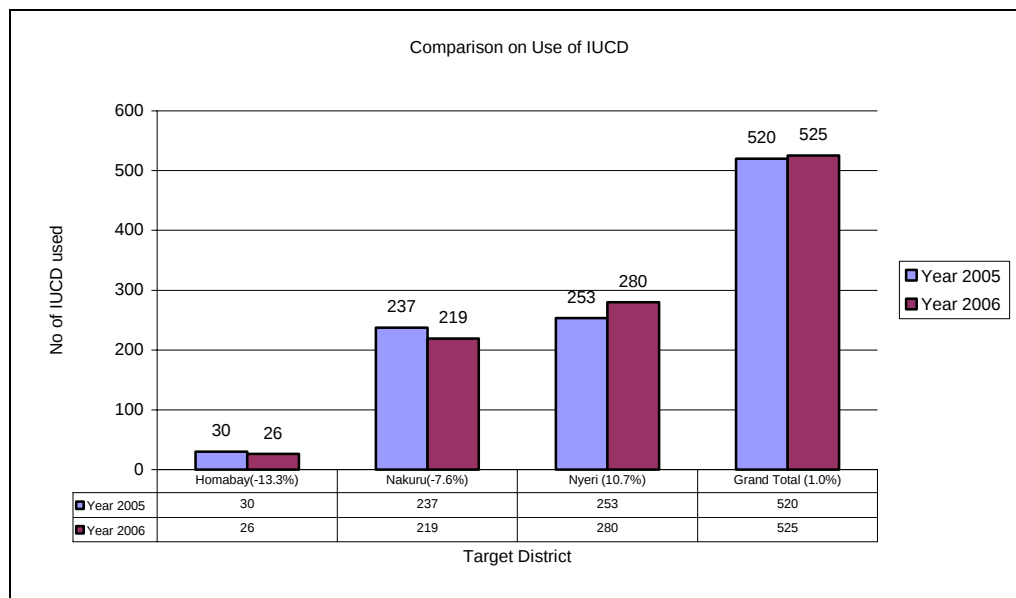


The number of revisits among clients also increased between 2005 and 2006. Homabay had the highest number of revisits (23%) followed by Nyeri (10%) and then Nakuru (2.3%).

3.1.4 Contraceptive methods used by clients

There has been an effort toward encouraging women to use long term family planning methods. During this study, it was found that the use of IUCD had increased by only about 1.0% between 2005 and 2006 overall. In Nyeri District, it rose by about 11% while in Nakuru District it decreased by 7.6% and in Homa bay use of IUCD decreased by 13% (Figure 8). The slow increase in the up take of IUCD may be attributed in part to community beliefs and misconceptions. For example, it is believed in many communities that the IUDC may ‘disappear in the uterus’ and that the string can be felt during intimate relations with a spouse. The fear of infection especially in facilities where clients may not be comfortable with IP procedures could also be a contributing factor. In addition, lack of skills among service providers and poor infrastructure in lower level facilities may influence the failure to use the IUCD. There is need for awareness creation to dispel myths, improve on infection prevention practices, additional training of service providers and provision of essential equipment that is supportive of the use of the IUCD.

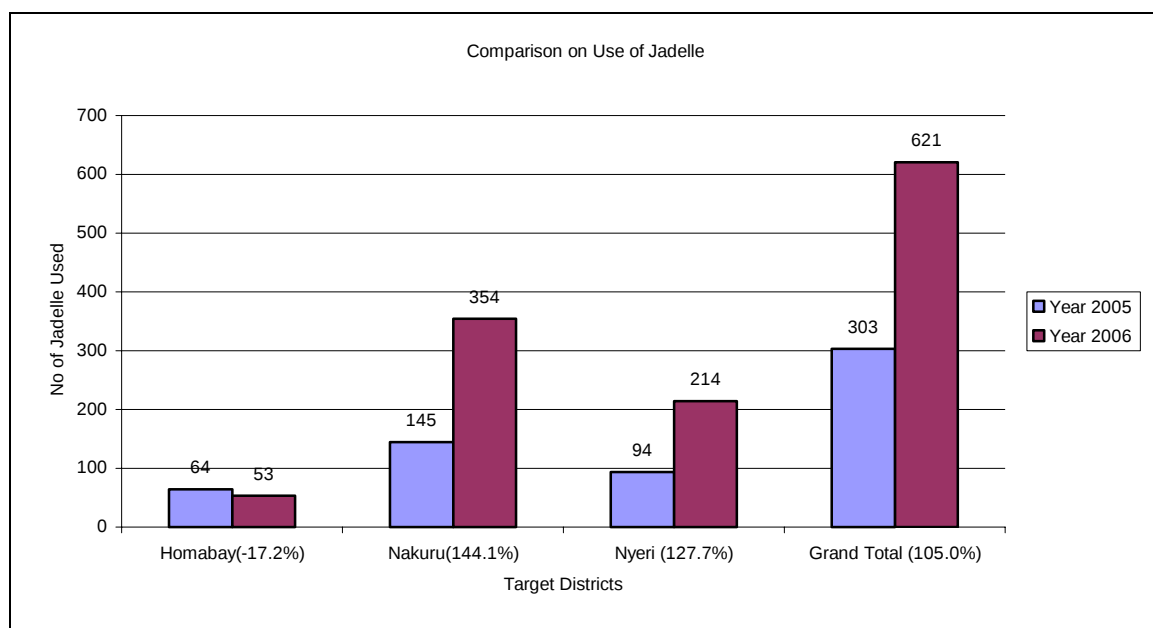
Figure 8 Comparison on Use of IUCD in Nyeri, Nakuru and Homabay



The use of Jadelle rose significantly by 105.0% over all. In Nakuru District alone it rose by 144.1% from the baseline. Fewer Jadelle were dispensed in Homabay District where the figure dropped by 17%. A chi-square test for association between the number of

Jadelle dispensed by district revealed a significance relationship (Chi-square=29.36, p-value=0.000). The increase in the use of Jadelle may be attributed to the training of service providers on its insertion and removal and also to its availability. Tubal ligation practice among clients was highest in 2006 with a 56.0% increase. In Nyeri District alone, the figure rose by 146.7%. In Nakuru District, the figure rose by 44% and declined by 37% in Homa bay (Figure 9). As noted earlier, the increase in Nyeri was a direct result of service providers using public fora to create awareness and the availability of the service.

Figure 9 Use of Jadelle in the three districts 2005 and 2006



Use of Depo Provera increased significantly between 2005 and 2006 (25.2%). The highest increase was in Nakuru (38%), Nyeri (19%) and Homa bay (9%). Use of oral contraceptives decreased in Nakuru (22%) but increased in Nyeri (18%) and Homa Bay (5%). The decrease may in part be due to the increased reliance on other contraceptives especially long term methods as indicated above.

The total number of male condoms dispensed between 2005 and 2006 increased 34.6%. The majority of condoms were distributed in Nakuru with Homabay having the highest increase (79.8%) of condoms dispensed. Nakuru District had the highest uptake of male

condoms. Dispensing of the female condoms decreased 37.5% between 2005 and 2006. This may partly be explained by the unavailability of the female condoms and issues related to its use by women.

3.1.5 Client perceptions on provider practice on contraceptives

The way a service provider interacts and communicates with a client is one of the determining factors on whether or not a client will return to the facility for continued services. To ascertain the service providers' practice, the clients were asked a set of questions including whether or not the service provider explained how to use the method. Table 7 shows clients' views on interactions with service providers. According to the clients many of the providers discussed the key issues to their satisfaction. Of note is the fact that few service providers are discussing negotiation for safe sex or whether the contraceptive methods provide protection against HIV/AIDS. This may be attributed to understaffing a factor that may not allow service providers adequate time with their clients, or cultural barriers in discussing these issues.

Table 7 Information shared with clients by Service providers

	Nakuru (n=51) %	Nyeri (n=81) %	Homabay (n=49) %	Total (n=181) %
Provider explained how to use the method	92.0	78.2	70.8	80.1
Provider said what to do if there is any problems using the method	88.0	74.4	84.8	81.0
Provider said when to return for a follow-up visit	92.0	94.9	89.6	92.6
Provider discussed how to negotiate with a partner about the method	60.0	41.0	39.6	46.0
Provider talked about whether the method gives any protection against STIs/HIV/AIDS	42.0	39.2	55.3	44.3

The majority of clients from each district said that they were satisfied with overall services offered by the providers. Clients reported overall satisfaction with, consultation time, method received, privacy and information received (Table 8). Additionally, the majority of clients reported that the waiting time was reasonable, although most clients wait at least one hour before they are seen by a provider. However, some clients did

report that some issues were not clear to them. In Nakuru (28%), Nyeri (20%) and Homa Bay (32%) clients said that some issues were still unclear to them. Suggesting the need for further training and an emphasis on client counseling.

Table 8 Clients overall evaluation of services received

		District			Total
		Nakuru(n=51)	Nyeri(n=81)	Homabay(n=49)	(n=181)
Felt that the consultation with the provider was long enough to ask all questions.	Yes	42 (82.4%)	68 (84.0%)	39 (79.6%)	149 (82.3%)
Satisfied with the method received.	Yes	45 (88.2%)	75 (92.6%)	45 (91.8%)	165 (91.2%)
Had enough privacy during consultation so that others could not HEAR.	Yes	44 (86.3%)	77 (95.1%)	37 (75.5%)	158 (87.3%)
Had enough privacy during your consultation so that others could not SEE.	Yes	46 (90.2%)	78 (96.3%)	35 (71.4%)	159 (87.8%)
Feel that the information shared with the provider will be kept private and confidential.	Yes	48 (94.1%)	79 (97.5%)	41 (83.7%)	168 (92.8%)
How were you treated by the provider during your visit to the clinic today	Very Well	38 (74.5%)	52 (64.2%)	26 (53.1%)	116 (64.1%)
	Well	13 (25.5%)	26 (32.1%)	21(42.9%)	60 (33.1%)
Was there anything unclear to you during your conversation with the provider	Yes	14 (27.5%)	16 (19.8%)	16 (32.7%)	46 (25%)

3.1.6 Contraceptive Stock-outs

Adequate and regular supplies of contraceptives are important in order to meet clients' needs. Stock outs of injectables were the most commonly reported. This could be due to the fact that it was also the most popular method. While most facilities (54%) did not experience stock outs in the last six months, 30% of the facilities reported that they did. Table 9 shows the number of facilities reporting stock –outs.

Table 9 Facilities reporting having had contraceptive Stock-outs

	No of Facilities Reporting Stockouts
Nakuru (n=11)	27%
Nyeri (n=10)	40%
Homabay (n=12)	25%

It is essential to ensure continued availability of contraceptives in all facilities. It is important to note that the Ministry of Health has over the recent past worked towards ensuring that this issue is addressed.

3.1.7 Knowledge and Skills still needed in family Planning

As noted earlier, only a small proportion of service providers were trained in each of the three districts. Hence, a large proportion of providers are yet to be trained. When service providers were asked what knowledge and skills they needed, those identified included Jadelle and Norplant insertion/ removal (table 10). Nearly half of providers in Nakuru indicated the need for basic family planning. This may be attributed to the fact that only 25 service providers were trained in the district. There is need to ensure that training on FP is scaled up in these districts especially to cover service providers who may not have been reached through the process of cascade. Similarly, such training is necessary in order to ensure that thorough training on long term methods takes place.

Table 10 Knowledge and skills still needed in family planning

	Nyeri(n=20)	Nakuru(n=20)	HomaBay(n=13)
	%	%	%
Jadelle insertion/removal	55.0	47.1	75.0
Norplant insertion/removal	45.0	17.6	66.7
Quality improvement (COPE)	50.0	88.2	33.3
IUCD insertion/removal	15.0	17.6	33.3
Basic family planning skills	35.0	47.1	16.7
Mini lap under local anesthesia	65.0	35.3	16.7
How to involve men in RH	45.0	76.5	8.3
Vasectomy	55.0	29.4	8.3
Infection prevention	5.0	17.6	8.3
STI/HIV prevention counselling	30.0	29.4	
STI/HIV diagnosis and treatment	30.0	29.4	

3. 2 Infection Prevention

The second objective of this project was to improve service provider practice through training on infection prevention (IP). 126 service providers were trained in infection prevention. The training emphasized the purpose of Infection Prevention (IP) which is to prevent disease transmission in the clinical and hospital setting, to minimize the risk of infection to clients and healthcare workers, including support staff and the community. Nosocomial infections are a significant problem throughout the world and are increasing, with rates ranging from 1% in some countries in Europe to more than 40% in parts of Asia, Latin America and sub-Saharan Africa.

During the training, the purpose of IP in healthcare facilities was emphasized. IP in clinical settings is meant to:

- Minimize infection due to microorganisms causing serious infections; and to prevent the transmission of serious life threatening diseases such as hepatitis B and HIV/AIDS
- Prevent the spread of infection by disrupting the disease transmission cycle

The training discussed standard precautions being a set of clinical practice recommendations designed to help minimize the risk of exposure to infectious materials, such as blood and other body fluids, by both clients and staff. Standard precautions help break the disease-transmission cycle at the mode of transmission step. This can be achieved through decontamination, cleaning, sterilization and disinfection. It has been observed that in many health facilities, the disposal of waste is not always in line with recommended international standards. It is not uncommon in many facilities to see poor waste disposal as depicted in figure 10 below.

Figure 10 Poor waste disposal in some health facilities



3.2.1 Medical Waste Disposal, Sterilization and Disinfection of Instruments as practiced in facilities

During this follow up study, it was found that all the health facilities had in place various infection prevention measures. Out of the 33 facilities visited, 16 facilities said they dispose of medical wastes, such as syringes and bandages, by burning them in an open pit. The majority of facilities use chemicals to disinfect their instruments. (See table 11 below).

Table 11 Medical waste disposal, sterilization and disinfection of instruments

	Nakuru (n=11)	Nyeri (n=10)	HomaBay(n=12)	Total (n=33)
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Medical Waste Disposal

Burn in an open pit	6(54.5%)	2(20.0%)	8(66.7%)	48.5%
Burn in the incinerator	5(45.5%)	6(60.0%)	2(16.7%)	39.4%
Buried	3(27.3%)	1(10.0%)	2(16.7%)	18.2%
Put in pit latrine	1(9.1%)	1(10.0%)	3(25.0%)	15.2%
Others	2(18.2%)		2(16.7%)	12.1%

Sterilization of Instruments

Steam sterilization /autoclave	7(63.6%)	7(70.0%)	5(50.0%)	20(60.6%)
Chemical	2(18.2%)	6(60.0%)	8(66.7%)	16(48.5%)
Boiling	4(36.4%)	5(50.0%)	3(25.0%)	12(36.4%)

Disinfection of Instruments

Chemical	5(45.5%)	7(70.0%)	6(50.0%)	18(54.5%)
Boiling	7(63.6%)	7(70.0%)	3(25.0%)	17(51.5%)
Not done here	1(9.1%)		2(16.7%)	3(9.1%)

39.4% of the facilities noted that waste such as bandages, syringes and other contaminated materials are burned in incinerators, 48.5% burned in an open pit and 18% buried. 15% put the waste materials in a pit latrine. It is important to note that multiple ways of disposing waste are utilized. In terms of sterilization of equipment, 60.6% of facilities use steam sterilization/autoclave, 36 % boiled the equipment and 48% used chemicals. Many of the service providers trained indicated their satisfaction with the training on IP.

The importance of IP in the context of family planning cannot be over emphasised. Proper practice of IP is essential in encouraging client use of contraceptives especially those that are invasive. Increased knowledge and awareness on transmission of infections especially HIV through contaminated instruments requires that service providers are up to date and practice infection prevention. During the training, it was clear that there are a lot of assumptions on IP and hand washing for example is taken for granted though not always practiced. Service providers also do not always have access to adequate disinfectants such as *jik* and many lack protective clothing. During the training, on

realising how much disinfectant was required for effective IP, one supervisor commented:

“I now understand why the *jik* gets finished so quickly in the facility. I always assumed it was due to wastage”

No doubt this realization will ensure that service providers are supported through having the necessary resources to ensure IP is practiced. In some of the facilities in Homabay, it was noted that the Constituency Development Fund (CDF) had been used to remove wooden floors replacing them with cement floors – which are much easier to maintain and to ensure IP.

3.3 Training on Supervision

The last objective of this IBP intervention was to train service providers on supervision. This activity was planned to strengthen the supervision skills of the provincial management teams who are and would be actively involved in the follow up of trained providers in the IBP districts which fall under their docket. The Purpose of the Course was to prepare service supervisors to improve the performance of service delivery systems and to ensure the provision of high quality services.

The emphasis of the supervisor training was to ensure that supervisors understand how to:

- Define desired performance for delivery site/s
- Assess performance
- Find root causes of performance gaps
- Select and implement appropriate interventions to improve performance
- Monitor and evaluate performance

A five day supervision training for district, provincial and national level managers from Nakuru, Migori, Homabay, Nyeri, and the Division of Reproductive Health, were updated on supervision knowledge and skills. A total of 41 supervisors were trained. The training on supervision was necessary as earlier indications were that supervision at best was erratic. During the base line, many service providers indicated that they do not get regular supervision.

The results based on this follow up survey after the training show that a lot still remains to be done (table 12). For example, only 26% of the service providers interviewed indicated that they had written job description. However, after the training and as a result of the Ministry of Health Rapid Results Initiative (RRI), 75% of service providers in Nyeri indicated that they had received performance appraisals at least once, although not necessarily in the last 3 months. The actual numbers remain low though. These providers

had received verbal/written recognition for a job well done in the past three months either from a supervisor, colleague, client or community member.

Table 12 Service provider experience with supervision

District	Have a written job description	Receive performance appraisals	Received verbal/written recognition for job well done
Nyeri(n=20)	10 (50.0%)	15 (75.0%)	16 (80.0%)
Nakuru(n=20)	2 (10.0%)	12 (60.0%)	8 (40.0%)
Homabay(n=13)	2 (15.4%)	5 (38.5%)	8 (61.5%)
Total (n=53)	14 (26.4%)	32 (60.4%)	32 (60.4%)

During the training, there were various issues raised in relation to supervision. Among these was the fact that most of the supervisors do not have any training on supervision as they are normally promoted on their job with no sensitization to the roles and responsibilities of a supervisor is created. Many of the supervisors noted that the training on supervision was a ‘new’ concept to them! One of the provisional health officers explained:

“I have been supervising for the last several years but I did not know that there was need to supervise against a standard! This training is an eye opener”.

The lack of written job descriptions for many of the service providers makes the work of supervisors difficult as they do not have a basis for evaluating and checking the performance of service providers. Job descriptions are urgently required. There is also need for Kenya to adopt standards for family planning that supervisors can use. Those trained on supervision appreciated this initiative. Many liked the opportunity to learn and to have demonstrations on effective supervision. This activity was further strengthened by the Ministry of Health Rapid Results Initiative (RRI) in which districts are expected to show results.

In the follow up support supervision by the MOH and JHPIEGO, there was indication that supervision was starting to take place in some health facilities. However, some challenges identified in relation to supervision included:

- Staff roles and responsibilities not well defined hence each team member is unaware of the others' duties.
- Translating the supervision checklists into report is difficult and documentation of supervision reports is time consuming hence mostly remains undone.
- Selection criteria for site visits is rarely set, thus some facilities get more attention than others.
- Team leaders have inadequate management skills.
- Vertical cadres report to different supervisors hence role conflicts prevent harmonization of teams.

Despite these continuing challenges, it is important to note that supervision has been incorporated in the district work plans because of the skills and knowledge acquired during the training. This is essential for sustainability.

4.0 CONCLUSIONS, CHALLENGES AND WAY FORWARD

4.1 Conclusions

JHPIEGO in collaboration with the Ministry of Health was able to train 126 service providers on FP, infection prevention and 41 supervisors in three districts: Nyeri, Nakuru and Homa Bay. The IBP initiative emphasizes the importance of quality reproductive health care that meets the expectations of the clients who seek such services. This in part requires that service providers have the necessary skills to be able to deliver the required services. In addition, it is important to have a contraceptive mix that provides protection, has fewer side effects and are easier to use. Such contraceptives are likely to encourage use among clients (Ushma, 2005)¹.

This endline survey shows that after the training, the use of contraceptives increased in all three districts with the exception of vesectomy and the female condom. In Homa Bay, uptake increased greatly for male condoms; moderately for other methods. In Nakuru, there was a mixed use of various FP methods with Depo Provera uptake being highest compared to other districts. In Nyeri there was an increase in the use of long term methods and especially Tubal Ligation. Overall, the use of family planning increased by 22% in Homabay, 21% in Nakuru and 3% in Nyeri respectively. The increase in Nakuru and Homa bay was well beyond that of the target set for this activity. In Nyeri, though, the increase was below 5%. These findings clearly indicate that training of service providers is important. However, there are various factors that need to be addressed in order to increase contraceptive uptake. For example, the fact that Jadelle was available during the training offered an opportunity to train service providers on its insertion and removal. This coupled with the availability created an opportunity for providers to offer Jadelle to their clients. Similarly, after the training, some service providers indicated that

¹ Ushma D. et al. Population reports series M No. 19 April 2005

they were now more confident in discussing and addressing clients concerns and offering a contraceptive mix. This was well articulated by a service provider who after the training commented:

“Inadequate knowledge and practice on “what is new” in this area, has lead us as service providers to offer “less cumbersome methods” such as Depo Provera. In addition to the work load in our facilities, I would say that lack of competency makes us avoid implant insertion all together”

Training on infection prevention is important in IBP and especially in reducing infections that may emanate from use of invasive contraceptives. Although many of the service providers interviewed indicated that they had adequate knowledge on IP, it is essential that IP is reinforced to avoid lapses in practice - that may endanger the clients and service providers.

Family planning (FP) services in Kenya are guided by clear national guidelines and policies. However, there are no national FP standards. Performance standards serve as a guide to providers, supervisors and trainers during the course of their work, to enable them to improve the quality of service. MOH/JHPIEGO, held a supervision workshop where this issue came out as key. An initial draft of standards was developed within the concept of two frameworks. Performance and Quality Improvement (PQI) framework, which formed the supervisory basis for the workshop and provided the facilitative supervision principles for health care supervisors, and the Kenya Quality Model (KQM). KQM has been used before in developing Standards for Maternal Care in Kenya published in 2002, and VCT accreditation Standards in Kenya. KQM is a national model developed by the Ministry of Health in 2000 to provide guidance and direction for quality management and improvement of health care delivery in Kenya. Based on three pillars: evidence-based practice, total quality management, and patient partnership², this would serve as an excellent framework to complete the process of developing FP standards.

²Information provided by the CNO's office

Traditionally, health care providers and researchers in the field of reproductive health have focused almost exclusively on women when planning programmes and services, especially with regard to family planning, prevention of unwanted pregnancy and promotion of safe motherhood. Efforts are now being made to broaden men's responsibility for their own reproductive health as well as that of their partners.³ It is evident that when men are involved, more women adopt and continue using FP methods. Indeed there is no “special formula” for involving men. Different approaches which are culturally acceptable, appropriate and have the potential to work, are required. This means that there is need for appropriately trained counsellors to interact with men and a broader range of topics needs to be dealt with (gender violence, female genital cut and promotion of positive behaviour towards women) that will look at the sexual and reproductive needs of men holistically—not simply from a family planning perspective—if efforts to reach men are to be successful. This was one of the key areas of training service providers in the three districts. However, as table 7 shows, service providers are still not adequately discussing male involvement and especially how to negotiate the use of a method with partner.

4.2 Challenges

Some of the key challenges that emerged during the implementation of this project include:

- The realization that a 5-days FP training is not adequate especially for service providers lacking technical update for many years
- Irregular contraceptive supplies. The findings show that the availability of contraceptives can lead to increased use. For example, the availability Jadelle, coupled with the training on insertion and removal led to a tremendous increase in all the districts
- Shortage of service providers for FP. Many providers indicated that FP tended to be relegated low priority given the lack of staff and in many cases FP practice was being overtaken by the emphasis placed on HIV/AIDS in the health care sector
- Lack of training and resources for support supervision

³ Programming for male involvement in RH. A report of the meeting of WHO regional advisors in RH. September 2001.

- Limited geographical access to FP services (for example, Homa Bay has only 25 facilities compared to 160 in Nyeri and 190 in Nakuru) in some of the districts
- Poor record keeping for tracking FP monitoring

It is recommended that:

- In addition to training, other factors that are supportive to women accessing contraceptives be addressed
- There is need to adequately address:
 - Cultural beliefs, misconceptions and practices
 - Lack of knowledge among service providers
 - Health systems issues (supplies, staffing, records)
- It is necessary to improve work environment for service providers
- It is essential to promote male involvement and community participation
- On the Job Training (OJT) should be reinforced

On supervision it is recommended that:

- If funding is available JHPIEGO in collaboration with the MOH conduct training for higher level of management teams, such as national, PMO's, PHO, PNO, PRCO, in order to ease the implementation of IBP and other programs at all levels
- JHPIEGO assist in facilitation of the development of written job descriptions with MOH/DRH/CNO's office
- With availability of funds, JHPIEGO facilitate support supervision of trained supervisors to enable them to practice knowledge and skills and follow up on the implementation of their action plans

4.3 Way forward

The IBP Kenya initiative has been implemented by the Ministry of Health in collaboration with JHPIEGO in three districts. The development of training materials on implementing best practices was achieved through the support of different partners. It is thus essential that the lessons learnt in the implementation in these initial districts is shared and used as a basis for scaling up training of service providers on FP, Infection

prevention and supervision. It is clear from this report that in addition to the above recommendations, as a way forward:

- There is need to train more service providers in the three districts on FP. Many providers have not been trained for a long time and as such, are not aware of the national guidelines and international standards. More importantly, as the results show, training is essential in improving provider practice;
- Given the positive results based on this intervention, the IBP needs to be scaled up beyond the three initial districts;
- The new MOH initiative on Rapid Results Initiative aims at one level to measure results in FP uptake with bi-monthly reports. This initiative offers an opportunity for partners working in the area of FP to “piggy bag” on the regular results and reporting to inform their interventions.