# Family Planning/ Long Acting and Permanent Methods (FP/LAPM)


## Training Plan 2011-2016

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## Acknowledgements

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## Foreword

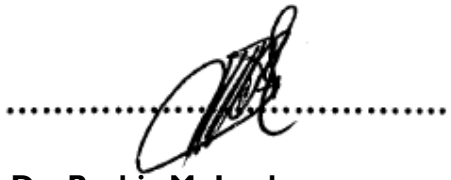
The FP program in Kenya has seen a reversal of the negative trends of the CPR that featured in the Nineties and early twenties. The recent DHS of 2009 showed a rise of the CPR to 46 % up from 39% in 2003. Whereas this is commendable, the bulk of the contribution to this uptake came from the short acting methods. The National Method mix is heavily skewed towards the short acting methods. However, to have a more cost –effective FP program and also to foster a more sustainable method mix and ensure women and couples have access to the contraceptive method of their choice, there is need to have the LAPMs in the mix. This is currently not the case as presently, the uptake of Long-Acting and Permanent Methods (LAPMs) of contraception is relatively low (5 % of the total contraceptive use).

In response to this need the DRH supported by its partners undertook initiatives to Revitalizing Long-Acting and Permanent Methods (LAPMs) and one such initiative, was the development of the LAPM strategy for improving the uptake of LAPMs. The National LAPMs strategy (2008-2010) emphasizes four main thematic areas of focus: Advocacy, Commodity security, Capacity building, Supervision and Demand creation. With regards to capacity building, the need to have service providers skilled in LAPMs service provision is emphasized.

For the health sector to ensure availability of health service providers with proficiency skills in LAPMs service provision, more investment is needed in competency-based training, both at pre-service and in-service levels. All health provider training institutions are expected to conform to the standardized national FP/LAPMs curriculum in addition to other international standards in their provision of pre-service training to contribute to delivery of quality family planning services including LAPMs.

It's due to the above need that the DRH with support from its partners undertook to develop a training plan for LAPMs. This training plan for LAPMs contributes towards the operationalization of the strategy and supports the process of repositioning family planning on the national agenda by ensuring that health service providers have adequate competencies for provision of comprehensive FP/LAPM services at the appropriate levels of health care. The plan addresses training at both pre- and in-service levels in line with the expected outputs of Vision 2030 and NHSSP II; taking into account specific competencies required to deliver services at the different KEPH levels. It aims at guiding the design, planning, coordination, and implementation of training activities with regard to the provision of FP/LAPM services.

I would like to thank all stakeholders including the LAPM task force members who worked tirelessly to develop this plan.



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## Background

Globally, 63 percent of women of reproductive age who are married or are in a union are using some form of contraception, either modern or traditional contraception. In developing countries, the contraceptive prevalence rate is 62 percent while it is 69 percent in developed nations. Sub-Saharan Africa has the lowest levels of contraceptive use (17-22 percent) among women who are married or in union, although a high proportion wants to delay or limit childbearing. In addition, the region has the highest unmet need for family planning (25 percent). On the contrary, Eastern Asian region has the highest CPR of 86 percent and lowest unmet need of 2 percent.

Family planning is a lifesaving phenomenon in that at once, it saves the lives of women and children, prevents mother to child transmission of HIV, while enabling couples to choose the number, spacing and timing of their children. There are four main LAPMs: IUCD and hormonal implants which are reversible; female sterilization and vasectomy which are permanent methods. LAPM are the safe, convenient and the most cost-effective FP methods.

The CPR for Kenya stands at 46 percent with majority of women using injectables (22%). Among currently married women, long acting reversible methods (IUCDs and Implants) are least popular being used by only 2% of women while female sterilization is used by 5%. The FP unmet need for women of reproductive age is 26 percent with adolescents (15-19) having the highest unmet need of 30 percent. Despite low use of LAPM, a significant proportion of currently married women either do not want any more children or would wish to have another child after 2 years.

While majority of community members are aware of the different family planning choices available, including LAPM, their use is clouded by the perceptions they have towards these methods. Clients' partner concerns, myths and misconceptions about the methods, believed effects LAPM have on clients' sexual health act as barriers to use. In addition provider preferences and bias, lack of skills to provide LAPM services and lack of equipment and infrastructure all hinder service use.

## Provision of FP/LAPM Services in Kenya

The KDHS 2008-09 report indicate that majority of the population obtain their contraceptive methods through the public sector (57 percent), followed by 36 percent from the private / FBO/NGOs sectors and 6 percent from the other sources. 67 percent of clients who undergo female sterilization obtain it from the government sector while 32 percent obtain from the private / FBO / NGO sector as shown in the table below

**TABLE 1: Percentage distribution of most recent source of FP method among users ages 15-49**

| Source | Female sterilization | Pill | IUD | Injectables | Implants | Male condom | Total |
|---|---|---|---|---|---|---|---|
| Public | 67 | 42 | 51 | 65 | 78 | 20 | **57** |
| Private/FBO/ NGO | 32 | 56 | 48 | 34 | 22 | 17 | **36** |
| Other (mobile, CBD, shop) | 0.7 | 1.6 | 1.2 | 0.5 | 0.0 | **60** | **6** |

Over 8 out of 10 facilities in Kenya offer temporary modern FP while less than 1 in 10 offers either male or female sterilization. Majority of facilities offering female sterilization are in Western (18%), Nyanza (14%) and Nairobi (10%).

Of the facilities offering FP services, only 25% have all the items needed to support quality counseling for FP. This includes the availability private room, individual client cards, FP guidelines and visual aids.

Besides limited health care provider knowledge only few facilities have the equipment, supplies, training, supervision, and quality assurance systems needed to provide FP/LAPMs. Innovative approaches have been tried in deferent settings and have yielded positive results in terms of increasing access to FP/LAPMs. These include: Tunza family health network by PSI, Social franchising by Marie Stopes and RH-output based approach.

Integration of HIV testing into FP/RH services has been shown to be feasible. Other opportunities for integration with FP/LAPM that have been identified in this plan include cervical cancer screening using visual inspection and youth-friendly services. Facility/clinic-based youth centers with appropriate staff may provide an opportunity for FP/LAPM service provision and advocacy.

The following is a summary of the salient issues that have emerged from the situation analysis of FP/LAPM training in Kenya;

## Who can provide FP services

Table 2 shows the cadres of service providers and the range of family planning services they are allowed to provide. **Community health workers or community based distributors:** are allowed to provide pills, condoms and refer clients who need other FP methods. This is in line with the community health strategy, the community RH package and Training CHW to give maternal and newborn messages: **Nurse / midwives: -** are allowed to provide family planning methods including the long-acting reversible methods with the exception of permanent methods. The retired midwives have great potential to provide quality services within the community and the modality for their training needs to be worked out.

**Registered clinical officers**: - are able to provide reversible FP methods. The provision of surgical FP methods by Registered Clinical Officers (RCOs) is still a grey area and needs more discussion. Although the law does not allow RCOs to provide surgical FP methods, the CO's Council is of the view that with adequate training RCOs, supported by close supervision are providing these services especially in rural areas where there are no doctors.

**Medical officers and obstetricians: -** are allowed to provide the whole range of methods including surgical methods.

**TABLE 2: Health provider cadres and the LAPM they are able to provide**

| **Staff cadre** | **Short-acting FP Methods** | | | **Long-acting FP Methods** | |
|---|---|---|---|---|---|
| | **Pills &EC** | **Condoms** | **Injectables** | **Long Acting (IUCD, Implants)** | **Permanent Methods (Vasectomy, BTL)** |
| Community health workers, CBD, Peer educators, shopkeepers | Yes | Yes | Education and refer | Education and refer | Education and refer |
| Pharmacists | Yes | Yes | Not sure | No | No |
| Nurses Nurse/midwives | Yes | Yes | Yes, | Yes | Couselling and refer |
| Registered clinical officers RCO- RH | Yes | Yes | Yes | Yes | Yes- Grey area |
| Medical officers Obstetricians | Yes | Yes | Yes | Yes | Yes |

As the private, NGO and FBOs are major sources of contraceptive methods for the population in Kenya; this training plan intends to target service providers from both the public and private sectors.

The implementation of this training plan is intended to go hand in hand with other national strategic documents that are being implemented by the Division of Reproductive Health (DRH) such as the community health strategy, the communication strategy, the National RH training plan (2007-2012), the National RH standards, the community RH package and the Family Planning Cost implementation Plan.

***Pre-service training***

Pre-service training provides an opportunity for a large number of health care providers to receive training in LAPM. Family planning is part of the curricular content for service providers at both diploma, higher diploma (in RH) and degree levels. The Nurses and the clinical officers pre-service curriculum takes the students through the LARC –Long Acting reversible contraception such as IUCDs and Implants and it also includes the Didactic aspect of the permanent methods. However, these Cadres are at present only allowed to provide IUCD and Implants. The Medical training institutions for these middle level cadres do experience challenges with respect to the provision of LARC. Some of these challenges includes; Commodity security for LARC. Short contact time and limited exposure to skills, limited Infrastructure, Student overload just to cite a few.

With regards to training in the provision of permanent methods, a procedure only conducted by medical doctors, medical training institutions experience the following challenges

- **Short contact time allocated to LAPM by training colleges**: at the University of Nairobi, very little time is allocated to training medical students on LAPM hence students graduate without having mastered the skills
- There is constant increase in student enrollment with no expansion of the teaching infrastructure.
- Limited exposure to practical skills by medical doctor interns at both medical schools and the internship centers
- Lack of effective monitoring and supervision in LAPM of the medical doctor interns
- Limited physical infrastructure
- Lack of standardized training materials
- Lack of linkages between the clinical training sites and the faculty staffs of the medical training colleges. The college lecturers / tutors and clinical instructors in the clinical areas may not communicate effectively. The tutors and the preceptors at the clinical training sites may not have the clinical training skills in LAPM

***In-service training***

In-service training remains a major source of continuous professional development for health care providers. In-service training updates service providers on emerging health issues, new technologies or skills that are evidence-based. Some of the skills not well learnt during pre-service training are perfected during in-service training, although the trainings are heavily donor dependent.

Currently there are 13 Decentralized Training Centers (DTC) whose role is to provide comprehensive RH training for service providers within a specific region. DTCs face challenges which include: high cost of the RH curriculum course to the provider, lack of financial resources to run the DTCs, limited training infrastructure including office space, lack of skills laboratories, and erratic supply of contraceptives.

The current RH curriculum though comprehensive is seen to be expensive and takes too long (takes five months). The course though relevant is not very attractive to private practitioners as they are unable to get 5 months off-duty. Suggestions have therefore been made for the course to be delivered in modular form so that service providers can choose to take modules of interest. There seems to be demand for the return of the six weeks FP course especially from private practitioners.

## The National FP/LAPM training plan

The goal of the National FP/LAPM Training Plan 2011-2016 is to expand provision of quality FP/LAPM services and sustain a demand creation process through the public, NGOs and private sectors. The plan aims at guiding the design, planning, coordination, and implementation of training activities with regard to the provision of FP/LAPM services within framework of the National Reproductive Health Strategy, the National Reproductive Health Policy and the National Reproductive Health Training Plan 2007-2012. The plan takes a supply demand approach (SDA), a concept that was initially developed by Acquire Project (2008). The plan pays cognizance to the fact that training of service providers in FP/LAPM is only one aspect of service delivery and has to go hand in hand with demand creation and availability of supplies. This training plan has 8 objectives:-

1. To build the capacity of health care providers in the provision of FP/LAPM services through in-service training
2. To strengthen the capacity of in-service training institutions at all levels
3. To strengthen institutional capacity of Medical Training Colleges including Universities on FP/LAPM training
4. To expand the availability and FP/LAPM services in the rural areas

5. To advocate for commodity security
6. To strengthen the capacity of health facilities in provision of FP/LAPM services
7. To promote public-private partnerships through NGO contracting, social marketing and franchising
8. To strengthen operations research and establish an effective monitoring and evaluation system for the FP/LAPM training.

This plan therefore identifies existing gaps and priorities in FP/LAPM training during both pre-service and in-service training. It outlines key strategic objectives, outcomes and lead activities to be undertaken to achieve the set objectives. The plan also defines roles and responsibility of different stakeholders and regulatory bodies with regards to FP/LAPM training.

- Suggestions have therefore been made for the course to be delivered in modular form so that service providers can choose their modules of interest.

- Traditional training approaches have often used didactic styles with service providers being trained outside their areas of operation. It is essential to include other training methodologies such as OJT to reduce on the cost and time away from the working station. Incorporation of the latter would require structural improvements at the health facility and availability of training/assessment guidelines and criteria for certification. In this respect the role of regulatory bodies will be critical. Other training approaches such as e-learning are also avenues that can enhance training.

- Operations research has been instrumental in providing the views from both the service providers and the user perspective on the use of LAPMs and will continue to inform policy formulation and development.

## Why do we need a FP/LAPM training plan?

The National LAPMs strategy (2008-2010)[1] emphasizes the need to have service providers skilled in LAPMs service provision. For the health sector to ensure availability of health service providers with proficiency skills in LAPMs service provision, more investment is needed in competency-based training, both at pre-service and in-service levels. This National LAPMs training plan aims at guiding the design, planning, coordination, and implementation of training activities with regard to the provision of FP/LAPM services. This is within the context of the National Reproductive Health Strategy (MOPHS & DRH 2009), the National Reproductive Health Policy (MOH/DRH 2007)[2] and the National Reproductive Health Training Plan 2007-2012 (MOH/DRH 2007)[3].

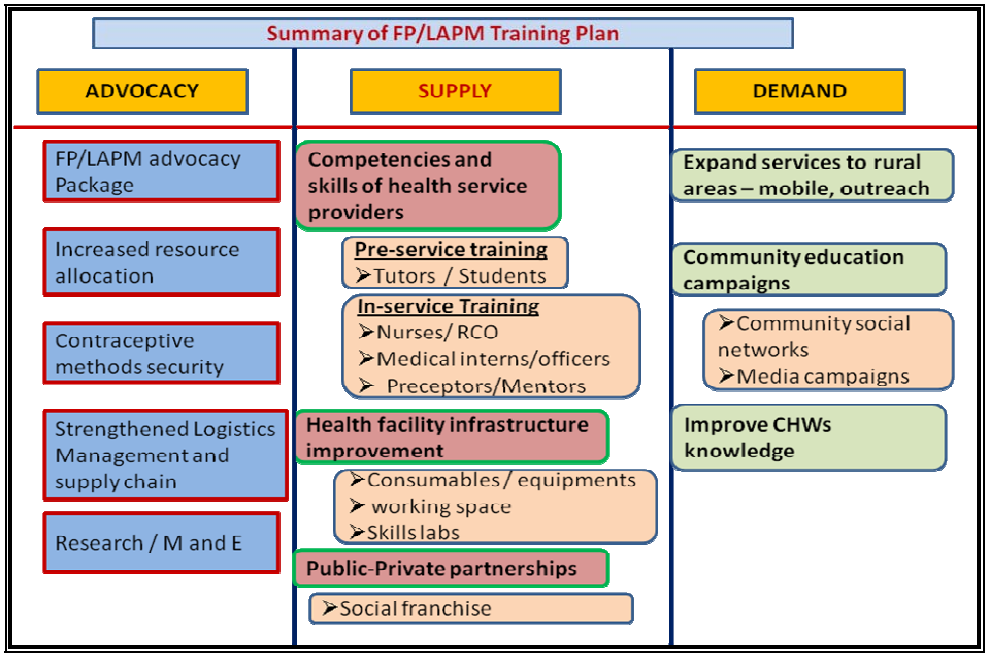
This training plan will support the process of repositioning family planning on the national agenda by ensuring that health service providers have adequate competencies for provision of comprehensive FP/LAPM services at the appropriate levels of health care. National LAPMs training plan addresses training at both pre- and in-service levels in line with the expected outputs of Vision 2030 and NHSSP II; taking into account specific competencies required to deliver services at the different KEPH levels. The training plan also:

- Identifies existing gaps and priorities in FP/LAPM training at in-service, service delivery and pre-service levels
- Outlines key strategic objectives, outcomes and activities to be instituted by both pre-service and in-service training institutions so as to enhance FP/LAPM training and service delivery
- The plan gives the estimated cost of implementing the training plan while flagging out the corresponding cost implications.
- Identifies the cadres to be trained in FP/LAPM service provision and potential areas of skills transfer
- Defines roles and responsibilities of various institutions and actors with regard to LAPMs training
- Provides a monitoring and evaluation framework to ensure sustainability and quality FP/LAPM training
- Development of a National LAPM training manual is on course by the FP technical working group, with technical assistance from EngenderHealth. The manual outlines the training content and will be used for training health service providers. Training of community health workers will draw from the Community RH package and the Training manual for Community health workers.

## Summary of FP/LAPM Training Plan

As shown in Figure 1, the National FP/LAPM training plan takes the **Supply Demand Advocacy (SDA)** service delivery model, an approach first implemented by the Acquire Project (ACQUIRE project 2008). The plan pays cognizance to the fact that service provider training is only one aspect of service delivery and that it has to go hand in hand with advocacy and demand creation initiatives. A trained service provider requires a supportive environment where the institutional and infrastructural framework is conducive for service delivery. In addition clients have to demand for the services and hence demand creation efforts have to constitute an integral part of the service delivery model. In addition to this model the Operations Research component has the added value of providing evidence for target training and service delivery.

**FIGURE 1: Summary of the FP/LAPM training plan**



## Goal of the FP/LAPM Training Plan

The overall goal of the FP/LAPM Training Plan is to expand the provision of quality FP/LAPM services and a sustained demand creation process through the public, NGOs and private sectors.

## Strategic Objectives of FP/LAPM Training

**Objective 1: To build the capacity of health care providers in the provision of FP/LAPM services [1] through in-service training**

**Outcome 1.1: a pool of trained FP/LAPM health service providers maintained at all levels of health care**

**Lead Activities**

1. To facilitate further analysis of health service provider training in FP/LAPM using existing national assessments surveys such as Kenya Service provider Assessment (KSPA), supervision reports and annual progress reports.
2. Facilitate dissemination of FP/LAPM training curricular and materials.
3. Develop and disseminate task oriented guidelines for OJT in FP/LAPM including VIA/VILI and HCT
4. Train 80 Regional Trainers of Trainers (TOTs) in FP/LAPM including VIA/VILI
5. Use a cascade system including OJT in the training of health care providers in FP/LAPM services provision
6. Use the existing CPD/CMEs at the facility level to promote knowledge and skills in LAPMs
7. Strengthen integrated support supervision of FP/RH including post training follow-up at all levels of health care

[1] Building the capacity of health care providers will include dispelling myths and misconceptions, and attitudes

**Objective 2: To strengthen the capacity of in-service training institutions at all levels**

**<u>Outcome 2.1:</u> Performance-based training achieved during in-service training**

**Lead activities**

1. Disseminate guidelines on OJT including certification criteria and evaluation processes.
2. Orient 200 trainers from decentralized RH training centers, MTCs, universities, FBOs, private, local government on FP/LAPM with a special focus on OJT.
3. Support the establishment of skills labs at 13 DTCs and other training institutions
4. Facilitate procurement of audio-visual teaching aids, equipment and anatomical models for the decentralized RH training centers and other training institutions.
5. Advocate for the use of ICT and e-learning in medical training institutions and DTCs
6. Provide logistical support to enable trainers from training sites including DTCs supervise their students in clinical areas / sites.
7. Develop the modular form of the Comprehensive RH training with FP/LAPM as one of the modules
    - ✓ Establish mechanisms for accreditation and certification of the modular RH course

**Objective 3: To strengthen institutional capacity of Medical Training institutions: Universities, MTCs, and private institutions on FP/LAPM training.**

**<u>Outcome 3.1:</u> Pre-service training institutions strengthened to ensure that graduates have basic minimum competencies for FP and LAPM service provision**

**Lead activities**

1. Facilitate consultative forums between medical training colleges as a way of identifying mechanisms of tailoring health service provider training to suit the market demand
2. Facilitate the updating of faculty tutors, lecturers and clinical preceptors in FP/LAPM service provision and VIA/VILI
3. Facilitate the establishment and strengthening of skill labs in Medical Training Colleges including universities
    - ✓ Construction / renovation of skill labs
4. Facilitate the procurement of appropriate teaching aids, models and equipment, for use in the skills labs of the medical training institutions.

5. Strengthen linkages between training institutions and clinical training sites
    - ✓ Support and strengthen consultative meetings / fora between the clinical instructors/ preceptors and tutors
6. Support the review of the curriculum for medical training institutions and reposition family planning training especially LAPMs
7. Support the harmonization and standardization of methods for assessing students at all training institutions and clinical placement sites

**Outcome 3.2: Strengthen clinical training sites for medical students and clinical officers' interns to facilitate training in FP/LAPM**

**Lead activities**

- Support the strengthening of the infrastructural capacity of internship centers so as to provide FP/LAPM services
- Enforce FP/LAPM as basic skills for medical[2]/ clinical officer interns and Nursing into the guidelines for registration by regulatory boards and councils

**Objective 4: To expand the availability of FP/LAPM services including rural areas, informal settlements, and special needs populations**

**Outcome 4.1: Strengthened communications and community outreach services with a special emphasis on long-acting and permanent contraceptive methods**

**Lead activities**

- Engage communities in a participatory manner to review the knowledge gaps and misconceptions on FP including LAPMs
    - ✓ Develop appropriate information packages on FP/LAPMs
    - ✓ Develop action plans for community dialogue/education campaigns
    - ✓ Intensify community education campaigns on different family planning choices and demystify myths and misconceptions surrounding the different methods
- Sensitize community members using success stories by clients to increase knowledge and create demand for FP/LAPM services
    - ✓ Indentify FP champions within the community
    - ✓ Design targeted messages to dispel myths and misconceptions on FP/LAPM use

[2] Guidelines for interns in medicine and dentistry, November 2010: GOK.

- ✓ Use the different media channels to disseminate educative messages on the use of FP/LAPM

- Improve contraceptive choice and access by promoting outreach service delivery
  - ✓ Support the provision of LAPMs through mobile and outreach static sites
  - ✓ Expand the training at the community level to include CHEWs to provide information, counsel and referral
  - ✓ Pilot the use of retired community midwives in providing long acting FP
  - ✓ train and support community health workers, pharmacists, and drug shop keepers on the wide range of FP method and referral for LAPM
- Facilitate role models or champions to support the utilization of FP/LAPM and cervical cancer screening services
- Work with local social community networks to change social and behavioral norms in support of family planning
  - ✓ Engage men, women, young people and special populations in supporting the use of FP/LAPM as well as cervical cancer screening

**Objective 5: To advocate for contraceptive methods security**

**Outcome 5.1: Ensured steady and reliable supply of family planning methods, including LAPM, and expendable medical supplies.**

**Lead activities:**

- Sensitize policy makers on the importance of family planning including LAPM
  - ✓ Develop an FP/LAPM advocacy package
- Support the districts to sensitize local community leaders, religious leaders on RH and FP/LAPM
- Lobby for increased resource allocation for the procurement of family planning methods including LAPM from GOK and development partners
  - ✓ Lobby budgetary officials from Ministries of Public Health and Sanitation, Medical Services and Finance and other relevant ministries for increased budget for RH/FP/LAPM
  - ✓ Government to increase its funding to meet 100% of the country's commodity contraceptive needs

**<u>Outcome 5.2:</u> a strengthened co-ordination mechanism that ensures contraceptive methods security at all levels of health care**

**Lead activities:**

- Orient service providers, on logistics management system at all levels on forecasting, procurement planning, inventory control, warehousing, transport and distribution
- Strengthen partnerships between the logistics unit of DRH and KEMSA in order to improve the distribution of RH commodities

**Objective 6: To strengthen the capacity of health facilities in provision of FP/LAPM services**

**<u>Outcome 6.1</u>:** Ensured availability of FP/LAPM commodities, equipments and expendable supplies

**Lead activities**

- Strengthen health infrastructure to increase access and quality in the provision of a balanced methods mix
- Facilitate the equipping of health facilities at all levels with equipments /supplies for insertion and removal of IUCD and implants as well as provision of surgical methods and VIA/VILI screening

**Objective 7: To promote public-private partnerships through NGO contracting, social marketing and franchising**

**<u>Outcome 7.1</u>: enhanced public-private partnerships in FP/LAPM service delivery**

**Lead activities**

- Support the establishment and scaling up of existing social franchises with a special focus on FP/LAPM
    - ✓ Expand the existing social franchise networks to include northern Kenya
    - ✓ Train private providers and NGO/FBO staff (Clinical officers and Medical officers) on the provision of Permanent FP methods

**Objective 8: To strengthen operations research and establish an effective monitoring and evaluation system for the FP/LAPM training**

**Outcome 8.1: Operations research promoted and conducted as an integral part of FP/LAPM service delivery**

**Lead activities**

- Support operations research to support FP/LAPM service delivery
    - ✓ Support evaluation of training and identify best practices
- Support research with a special focus on socio-cultural determinants of contraceptive use
- Hold stakeholder workshops for dissemination of research findings and best practices
    - ✓ Support the use of other channels of information dissemination – websites etc

## FP/LAPMs Training Plan Management and Coordination

### Role of Ministry of Public Health and Sanitation, Division of Reproductive Health

The Ministry of Public Health and Sanitation, through the Division of Reproductive Health (DRH) is spearheading the implementation of this training plan and has the key role of coordinating all the training in RH including FP/LAPMs.

### Role of the Provincial RH Training and Supervision Teams

The PRHTs have a training and supervisory role incorporating the DHMTs and the FBOs based in their provinces. As the TOTs expand they begin to assume more of the monitoring and supervisory role while further training of TOTs is relegated more to the DHMTs. They will be the custodians of training data for the province, a copy of which is forwarded to DRH.

### Role of DHMTs

The DHMT will work together with PRHTs to serve as TOTs in training of service providers and they have the key role of supporting OJT within their districts. They will also coordinate and monitor the training of Community Health Extension Workers (CHEWs) including retired midwives and Community Health workers (CHWs) at the community level.

### The role of Training Institutions

Training institutions conduct pre-service training and in some cases in service training. They are also responsible for curriculum development, review and certification of the graduates. It is expected that the approved university-based medical and nursing schools, the KMTCs and the private and mission medical training hospitals will conform to the standardized national FP/LAPMs

curriculum in addition to other international standards in their provision of pre-service training to contribute to delivery of quality family planning services including LAPMs.

### The Role of Development Partners

Some development partners are already involved in research and training in FP/LAPPMs. It is expected that this role which includes scale up of trainings will continue particularly in support to the repositioning of family planning services especially the LAPMs in line with the FP/LAPMs training plans and priorities.

**TABLE 3: FP/LAPM training plan matrix**

| Strategic objectives / Outcomes | Verifiable Indicators | Source of verification | Responsible Institution | Budget estimate USD | Possible source of funds | Assumptions |
|---|---|---|---|---|---|---|
| **I: SUPPLY** | | | | | | |
| **Objective 1: To build the capacity of health care providers in the provision of FP/LAPM services through in-service training** | | | | | | |
| **Outcome 1.1: A pool of trained FP/LAPM health service providers maintained at all level of health care** | | | | | | |
| **Lead Activities:**<br>1.1. To facilitate further analysis of health service provider training in FP/ LAPM training using existing data such as Kenya Service Provider Assessment (KSPA), supervision and annual reports at DRH. | Number or proportion of health providers trained in FP/LAPMs | Report on further analysis | DRH | 30,000 | USAID/ FHI | Data / reports available |
| 1.2. Facilitate dissemination of FP/LAPM training materials | National FP/LAPM training materials available and in use | Report | DRH<br>Engender Health | 50,000 | USAID/ Engender health | National adaption/ endorsement |
| 1.3. Develop and disseminate task oriented guidelines for OJT in | Number or proportion of health | Guidelines available | DRH | 75,000 | USAID/ Jhpiego | Availability of the multidisciplinary |

| Strategic objectives / Outcomes | Verifiable Indicators | Source of verification | Responsible Institution | Budget estimate USD | Possible source of funds | Assumptions |
|---|---|---|---|---|---|---|
| FP/LAPM including VIA/VILI and HTC | facilities having and using task oriented guidelines | | | | | task force group |
| 1.4. Train 80 Regional Trainers of Trainers (TOTs) per year in FP/LAPM including VIA/VILI | No. of regional TOTs trained | Reports | DRH and partners | 250,000 | | Required level and competence of potential TOTs |
| 1.5. Use a cascade system including OJT in the training of health care providers in FP/LAPM services provision | No. of service providers trained | Reports | DRH/ partners | 250,000 | | National adoption of the training approach |
| 1.6. Use the existing CPD / CMEs at the facility level to include OJT | Proportion of facilities conducting training including OJT | Reports | Facility in charges<br>RH coordinators | 40,000 | | Willingness by service providers to accept OJT |
| 1.7. Strengthen integrated support supervision of FP/RH including post training follow up at all levels of health care | No of districts/units supervised | Reports | DRH/ RH coordinators | 120,000 | | Availability of integrated tools for supervision<br>Allocation of funds for supervision |

| Strategic objectives / Outcomes | Verifiable Indicators | Source of verification | Responsible Institution | Budget estimate USD | Possible source of funds | Assumptions |
|---|---|---|---|---|---|---|
| **Objective 2: To strengthen the capacity of in-service training institutions at all levels** | | | | | | |
| **<u>Outcome 2.1:</u> Performance-based training achieved during in-service training** | | | | | | |
| **Lead Activities:**<br>2.1. Disseminate guidelines on OJT including certification criteria and evaluation processes. | OJT guidelines disseminated<br>FP standards including<br>LAPM guidelines | reports | DRH<br>JHPIEGO | 135,000 | | Approval of the guidelines |
| 2.2. Orient 200 trainers from decentralized RH training centers and FBOs, NGOs, private, Local government on FP/LAPM with a special focus on OJT | No of trainers from DTCs and MTCs and other training institutions oriented on FP/LAPM | Reports | DRH and Partners | 250,000 | | Availability of trainers |
| 2.3. Support the establishment of skills labs at 13 DTCs, and other training institutions | No of skills lab established<br>Proportion of training institutions | Reports | DRH & partners | 400,000 | USAID/ FHI | Availability of space for skills lab |

| Strategic objectives / Outcomes | Verifiable Indicators | Source of verification | Responsible Institution | Budget estimate USD | Possible source of funds | Assumptions |
|---|---|---|---|---|---|---|
| | with skills labs | | | | | |
| 2.4. Facilitate procurement of audio-visual teaching aids, equipment and anatomical models for the decentralized RH training centers and other training institutions. | No. of audiovisual teaching aids, equipments and models procured for the decentralized RH training centers<br><br>In other pre-service training institutions | Reports | DRH and partners | 2,000,000 | | Expedition of Procurement procedures |
| 2.5. Advocate for the use of ICT and e-learning in medical training institutions and DTCs | No of MTC and medical training institutions with ICT facilities<br><br>No of MTC and medical training institutions with e-learning facilities | Reports | DRH and partners | | | Institutional policy support |

| Strategic objectives / Outcomes | Verifiable Indicators | Source of verification | Responsible Institution | Budget estimate USD | Possible source of funds | Assumptions |
|---|---|---|---|---|---|---|
| 2.6. Provide logistical supports to enable trainers from DTCs supervise their students in clinical areas / sites. | Proportion of training institutions whose students are supervised | Reports | DRH and Partners | 250,000 | | Availability and release of trainers |
| 2.7. Develop the modular form of the Comprehensive RH training with FP/LAPM as a module<br>✓ Establish mechanisms for accreditation and certification of the modular RH course | Number of institutions using modular curriculum<br>Number of training institutions with accreditation and certification in place | Reports | DRH/ Partners | 100,000 | USAID/JHPIEGO | Consensus on the type of curriculum |
| **Objective 3: To strengthen institutional capacity of Medical Training institutions including Universities, MTCs, private institutions on FP/LAPM training** | | | | | | |
| **<u>Outcome 3.1:</u> Pre-service training institutions strengthened to ensure that graduates have basic minimum competencies for FP and LAPM service provision** | | | | | | |
| **Lead Activities:**<br>3.1. Facilitate consultative forums | | | | | | Agreement on the agenda |

| Strategic objectives / Outcomes | Verifiable Indicators | Source of verification | Responsible Institution | Budget estimate USD | Possible source of funds | Assumptions |
|---|---|---|---|---|---|---|
| between medical training colleges as a way of identifying mechanisms of tailoring health service provider training to the market demand. | No. of consultative meetings held | Reports | DRH<br>MTC<br>Universities and other training institutions<br>Designated clinical sites | 50,000 | USAID/FHI | |
| 3.2. Facilitate the updating of faculty tutors, lecturers and clinical preceptors in FP/LAPM service provision and VIA/VILI | No of tutors/ lecturers / preceptors updated | Reports | DRH<br>MTCs<br>Universities and other medical training institutions | 250,000 | USAID/FHI | Administrative Logistics |
| 3.3. Facilitate the establishment and strengthening of skill labs in Medical Training Colleges including universities | No of skills labs established | Reports | DRH<br>Universities<br>MTC<br>Partners | 400,000 | | Supportive University and |

| Strategic objectives / Outcomes | Verifiable Indicators | Source of verification | Responsible Institution | Budget estimate USD | Possible source of funds | Assumptions |
|---|---|---|---|---|---|---|
| ➢ Construction / renovation of skill labs | No. skills labs renovated | Reports | DRH<br>Universities<br>MTC<br>Partners | | | MTC management |
| 3.4. Strengthen linkages between training institutions and clinical training sites | No of consultative meetings held per quarter | Minutes/Reports | DRH<br>Heads of Designated Training institutions and clinical sites | 200,000 | | Administrative support |
| ➢ Support and strengthen consultative meetings / fora between the clinical instructors/ preceptors and tutors | No of consultative meetings held per quarter | Minutes/Reports | DRH | | | Administrative support |
| 3.5 Support the review of the curriculum for medical training institutions and reposition family | No of consultative meetings held<br>Number of medical | Reports | DRH<br>Universities Obs/Gyn | 120,000 | | Institutional policy support |

| Strategic objectives / Outcomes | Verifiable Indicators | Source of verification | Responsible Institution | Budget estimate USD | Possible source of funds | Assumptions |
|---|---|---|---|---|---|---|
| planning training especially LAPMs | schools/colleges using a reviewed curriculum that includes LAPMs | | Department<br>MTCs and other medical training institutions | | | |
| 3.6. Support the harmonization and standardization of methods for assessing students at all training institutions and clinical placement sites | Revised log books | Reports | DRH<br>University-Obs/Gyn Department<br>Other medical training institutions<br>Regulatory bodies | 100,000 | | Consensus on methods of assessment |
| **Outcome 3.2. Strengthen clinical training sites for medical students and clinical officers interns to facilitate training in FP/LAPM** | | | | | | |
| **Lead Activities** | | | | | | |

| Strategic objectives / Outcomes | Verifiable Indicators | Source of verification | Responsible Institution | Budget estimate USD | Possible source of funds | Assumptions |
|---|---|---|---|---|---|---|
| 3.8. Support the strengthening of the infrastructural capacity of internship centers for provision of FP/LAPM services | Proportion of facilities with adequate infrastructure for FP/LAPM | Reports | MTC<br>Health facility managers | 200,000 | | Availability of Space |
| 3.9. Support the inclusion of FP/LAPM as basic skills for medical / clinical officer/Nursing interns into the guidelines for registration by regulatory boards or councils | No of Regulatory boards with these requirements | Reports | MOH<br>UoN<br>KM&DP board | 80,000 | | Regulatory guidelines in place<br>Support from regulatory bodies |
| **II: DEMAND**<br>**Objective 4: To expand the availability of FP/LAPM services to all including rural, informal settlements and special needs populations** | | | | | | |
| **<u>Outcome 4:</u> Strengthened communications and community outreach services with a special emphasis on long-acting and permanent contraceptive methods** | | | | | | |
| **Lead activities**<br>4.1. Engage communities in a participatory manner to review the | Number of advocacy meetings at | | DRH and | | | Availability of |

| Strategic objectives / Outcomes | Verifiable Indicators | Source of verification | Responsible Institution | Budget estimate USD | Possible source of funds | Assumptions |
|---|---|---|---|---|---|---|
| knowledge gaps and misconceptions on FP including LAPMs<br>➢ Develop appropriate information packages on FP/LAPMs<br>➢ Develop action plans for community dialogue/education campaigns<br>➢ Intensify community education campaigns on different family planning choices and demystify myths and misconceptions surrounding the different methods | community level<br>Information package developed<br>Community work plans<br>No. of community educational campaigns | Reports | Partners | 800,000 | | implementing institutions |
| 4.2. Sensitize community members using success stories by clients to increase knowledge and create demand for FP/LAPM services<br>➢ Identify FP Champions within the community | No of sensitization meetings held<br>Number of new acceptors for FP/LAPM services<br>Number of champions in the community | Reports | DRH<br>CBOs | | | Availability of implementing institutions |

| Strategic objectives / Outcomes | Verifiable Indicators | Source of verification | Responsible Institution | Budget estimate USD | Possible source of funds | Assumptions |
|---|---|---|---|---|---|---|
| ➢ Design targeted messages to dispel myths and misconceptions on FP/LAPM use | No of targeted messages designed and disseminated | Reports | DRH<br>Provincial teams<br>District teams | 300,000 | | Cooperation from the target communities |
| ➢ Use the different media channels to disseminate educative messages on the use of FP/LAPM | No of channels used to disseminate messages | Reports | DRH<br>Provincial teams<br>District teams | 400,000 | | Cooperation from media houses |
| 4.3. Improve contraceptive choice and access by promoting outreach service delivery | | Reports | DRH<br>Provincial teams<br>District teams | 200,000 | | Efficient procurement and Pipeline distribution |
| ➢ Support the provision of FP/LAPMs through mobile and outreach | No of organization providing mobile services | Reports | DRH<br>Partners | | | Availability of receptive clients<br>Availability of |

| Strategic objectives / Outcomes | Verifiable Indicators | Source of verification | Responsible Institution | Budget estimate USD | Possible source of funds | Assumptions |
|---|---|---|---|---|---|---|
| static sites | | | NGO/CBOs | | | contraceptive commodities |
| ➢ Expand the training at the community level to include CHEWs to provide information, counsel and referral<br>➢ Pilot the use of retired community midwives in providing long acting FP | No. of CHEWs trained per region<br>No of retired and community midwives trained on Long Acting methods | Reports | DRH<br>Pop council<br>Partners | 260,000 | | Availability of CHEWS and community midwives to be trained |
| ➢ train and support community health workers, pharmacists, and drug shop keepers on the wide range of FP method and referral for FP/LAPM | No in each category trained per region | Training reports | DRH and partners | 400,000 | | |
| 4.4. Facilitate role models or champions to support the utilization of FP/LAPM and | No. of champions identified | Reports | DRH | 100,000 | USAID/FHI | Availability of champions and |

| Strategic objectives / Outcomes | Verifiable Indicators | Source of verification | Responsible Institution | Budget estimate USD | Possible source of funds | Assumptions |
|---|---|---|---|---|---|---|
| cervical cancer screening services | | | | | | role models |
| 4.5. Work with local social community networks to change social and behavioral norms in support of family planning | No of sensitization and advocacy workshops key social and behavioral norms in adopted | Reports | DRH<br>Provincial teams<br>District teams | 400,000 | | Competing priorities as obstacle to buy-in from target communities |
| ➢ Engage men, women, special populations and young people in supporting the use of FP/LAPM as well as cervical cancer screening | No of sensitization and advocacy workshops | Reports | District teams and CHEWs<br>Community leaders | 200,000 | | |
| **III: ADVOCACY** | | | | | | |
| **Objective 5: To advocate for contraceptive methods security** | | | | | | |
| **<u>Outcome 5.1:</u> Ensured steady and reliable supply of family planning methods, including LAPM, and expendable medical supplies** | | | | | | |

| Strategic objectives / Outcomes | Verifiable Indicators | Source of verification | Responsible Institution | Budget estimate USD | Possible source of funds | Assumptions |
|---|---|---|---|---|---|---|
| **Lead Activities:**<br>5.1. Sensitize policy makers on the importance of family planning including LAPM | No. of advocacy meetings held<br><br>No of meetings held with local leaders | Reports | DRH<br>NCAPD | 150,000 | USAID/FHI | National level policy support |
| ➢ Develop an FP/LAPM advocacy package | FP/LAPM advocacy package developed | Reports | DRH | 60,000 | USAID/FHI | |
| 5.2. Support the districts to sensitize local community leaders, religious leaders on RH and FP/LAPM | No of meeting held with community and religious leaders | Reports | DRH | 300,000 | | |
| 5.3. Lobby for increased resource allocation for the procurement of family planning methods including LAPM from GOK and development partners | No of advocacy meetings held | Budget GOK books and expenditure | DRH<br>Partners<br>NGOs | | | National policy level support |
| ➢ Lobby budgetary officials from Ministries of Public | Increased budgetary allocations for | | | 100,000 | USAID/FH | |

| Strategic objectives / Outcomes | Verifiable Indicators | Source of verification | Responsible Institution | Budget estimate USD | Possible source of funds | Assumptions |
|---|---|---|---|---|---|---|
| Health and Sanitation, Medical Services and Finance and other relevant ministries for increased budget for RH/FP/LAPM | RH/FP in printed estimates | reports | | | I | Support from stakeholders |
| ➢ Government to increase contraceptive funding by 50 percent | | | | | | |
| **Outcome 5.2: A strengthened co-ordination mechanism that ensures contraceptive methods security at all levels of health care** | | | | | | |
| 5.4. Orient service providers on logistic management system at all levels on forecasting, procurement planning, inventory control, warehousing, transport and distribution | Adequate quantities of supplies | KEMSA reports | DRH and partners | 250,000 | USAID/MSH | Expedite Procurement procedures |
| 5.5. Strengthen partnerships between the logistics unit of DRH and KEMSA and other | Number of meetings | Reports | DRH | 50,000 | USAID/MSH | KEMSA and DRH willing to |

| Strategic objectives / Outcomes | Verifiable Indicators | Source of verification | Responsible Institution | Budget estimate USD | Possible source of funds | Assumptions |
|---|---|---|---|---|---|---|
| partners in order to improve the distribution of RH commodities | | | | | | cooperate |
| **Objective 6: To strengthen the capacity of health facilities in provision of FP/LAPM services** | | | | | | |
| **<u>Outcome 6.1</u>: Ensured availability of FP/LAPM commodities, equipments and expendable supplies** | | | | | | |
| **Lead Activities:**<br>6.1. Strengthen health infrastructure to increase access and quality in the provision of a balanced methods mix | Proportion of facilities with a balanced quantities of method mix | Reports | MOH | 200,000 | | Availability of contraceptive supplies |
| 6.2. Facilitate the equipping of health facilities at all levels with equipments/supplies for insertion and removal of IUCD and implants as well as provision of surgical methods and VIA/VILI screening | Proportion of facilities with adequate/appropriate equipment | Reports | MOH | 300,000 | | Availability of space and infrastructure for service provision |
| **Objective 7: To promote public-private partnerships through NGO contracting, social marketing and franchising** | | | | | | |

| Strategic objectives / Outcomes | Verifiable Indicators | Source of verification | Responsible Institution | Budget estimate USD | Possible source of funds | Assumptions |
|---|---|---|---|---|---|---|
| **<u>Outcome 7.1</u>: enhanced public-private partnerships in FP/LAPM service delivery** | | | | | | |
| **Lead Activities:**<br>7.1. Support the establishment and scaling up of existing social franchises with a special focus on FP/LAPM | No of social franchise set or scaled up | Reports | DRH<br>Partners | | | Policy support |
| ➢ Expand the existing social franchise networks to include northern Kenya | No of social franchise networks set up and including Northern Kenya | Reports | DRH<br>Partners | 300,000 | | Private and NGO providers willing to join the franchise network |
| ➢ Train private providers, NGO/ FBO staff (service providers (Clinical officers, nurses and Medical officers) on the provision of Permanent FP methods | No of private service providers trained in FP/LAPM | Reports | DRH<br>Partners | 200,000 | | |
| **IV: OPERATIONS RESEARCH and M & E**<br>**Objective 8: To strengthen operations research and establish an** | | | | | | |

| Strategic objectives / Outcomes | Verifiable Indicators | Source of verification | Responsible Institution | Budget estimate USD | Possible source of funds | Assumptions |
|---|---|---|---|---|---|---|
| **effective monitoring and evaluation system for the FP/LAPM training** | | | | | | |
| **<u>Outcome 8.1:</u> Operations research promoted and conducted as an integral part of FP/LAPM service delivery** | | | | | | |
| **Lead activities**<br>8.1. Support operations research to support FP/LAPM service delivery<br>✓ Support evaluation of training and identify best practices | No of operations research commissioned and funded | Reports | DRH<br>Partners | 200,000 | USAID/FHI<br>USAID/JHPIEGO | Availability of appropriate skills |
| 8.2: Support research with a special focus on socio-cultural determinants of contraceptive use | | Reports | DRH<br>Partners | 250,000 | USAID/FHI<br>USAID/JHPIEGO | Prioritization of research<br>Availability of research findings to disseminate |
| 8.3: Hold stakeholder workshops for dissemination of research findings and best practices<br>✓ Support the use of other | No of dissemination workshops held | Reports | DRH<br>Partners | 100,000 | | |

| Strategic objectives / Outcomes | Verifiable Indicators | Source of verification | Responsible Institution | Budget estimate USD | Possible source of funds | Assumptions |
|---|---|---|---|---|---|---|
| channels for information dissemination e.g. websites | | | | | | |

## Annex I: Global situation of Family Planning

Globally, 63 percent of women of reproductive age who are married or are in a union are using some form of contraception, either modern or traditional contraception. In developing countries, the contraceptive prevalence rate is 62 percent while it is 69 percent in developed nations (results from 2007 data). Over the past ten years (since year 2000) regions with the lowest CPR have shown little or no progress towards increase in contraceptive use. In 2007 the global levels of unmet need for family planning were at 11 percent while that of developing countries were at more that 24 percent during the same period (UNFPA 2010)[4].

Sub-Saharan Africa has the lowest levels of contraceptive use (17-22 percent) among women who are married or in union, although a high proportion wants to delay or limit childbearing. In addition to this, the region has the highest unmet need for family planning (25 percent). On the contrary, Eastern Asia is the region with the highest CPR of 86 percent and lowest unmet need of 2 percent. Since the year 2000, the contraceptive uptake by clients has stalled while the total global investments in FP are at their lowest levels (UNFPA 2010).

**Table 4: CPR and unmet need for FP by region 1990, 2000 & 2007**

| MDG Region | Contraceptive prevalence – any method (%) | | | Unmet need for family planning (%) | | |
|---|---|---|---|---|---|---|
| | 1990 | 2000 | Approx 2007 | 1990 | 2000 | Approx. 2007 |
| World | 55.2 | 61.3 | 63.1 | 13.2 | 11.5 | 11.2 |
| Developing regions | 52.2 | 59.6 | 62.0 | 13.7 | 11.8 | 11.4 |
| Sub-Saharan Africa | 12.2 | 20.0 | 21.5 | 26.5 | 24.1 | 24.8 |
| Eastern Asia | 77.7 | 85.7 | 86.4 | 3.3 | 2.4 | 2.3 |
| South-East Asia | 48.3 | 57.0 | 61.9 | 15.1 | 11.0 | 10.9 |
| Developed regions | 69.9 | 70.5 | 69.3 | -- | -- | -- |

Whereas 2008 figures show that more than half of women of reproductive age in developing countries (818m) want to avoid pregnancy, 17 percent of these women are not using any method while 9 percent use traditional methods. It is estimated that women with unmet need for contraceptives account for 82 percent of all unintended pregnancies (Singh et al 2009)[5].

## Annex II: Situation of Long Acting Permanent Methods (LAPM)

Long acting methods including intrauterine devices (IUCDs), and hormonal implants, and permanent methods (female sterilization and vasectomy) are by far the most effective form of modern contraception. They are safe, convenient, cost-effective and suitable for use by most women of all ages intending to delay, space or limit births, and are often popular among women when made available and affordable(FHI, 2007a ).

LAPM do not require continuous supply and therefore impose less strain to the health system. Discontinuation rates for LAPM are lower compared to short term methods. Worldwide discontinuation rates after one year are much lower for implants (6 percent) and IUCDs (16 percent) than for oral contraceptives (48 percent) and injectables (49 percent). Long acting methods are suitable for women who desire to delay a first birth, or space or limit subsequent births. In spite of this, the use of LAPM for delaying, spacing or limiting births is low in many developing countries.

Permanent methods would meet the needs of women who have assumed their desired fertility and do not want any more children. Female sterilization remains the most common contraceptive method used globally preferred by 21 percent of married women, while the IUCD is preferred by 14 percent of the same (Figure 1 and 2)[6]. However, LAPMs are used by only a small proportion of women from Sub-Saharan Africa, 2 percent or less. Their use has therefore not kept pace with that of short-acting methods such as pills and injectables.

There exists evidence to demonstrate that there is unmet need for LAPMs by women in Sub-Saharan Africa since a large proportion of women who want to stop childbearing are not using a LAPM. A review of data from DHS in Sub-Saharan Africa between the period 2003-2005 showed that although more than 20 percent of women do not want any more children, fewer that 7 percent of these women are using a LAPM, rather they are using short-acting methods (FHI 2007a[7]). Although women from Sub-Saharan Africa also prefer to space their birth by more than two years, most births occur closer than the stated time period. Availability of better FP services including long acting, reversible methods such as IUCDs and implants would work for healthier timing and spacing of pregnancies (FHI 2007a).

One of the efforts used to improve access to LAPM in 22 countries was the AQUIRE Project which was implemented between the periods 2003-2008. The aim of the project was to increase access to and improve the quality of provision of FP/RH services particularly LAPM. Evaluation results showed the project had a steady increase in the number of clients using LAPM over the five year period as shown in figure 2 below with the majority of clients using IUCD (Figure 3).

One of the major approaches used to expand use of LAPMs was the Supply-Demand-Advocacy (SDA) programming model. This model used integrated approaches that included community engagement coupled with communications and marketing efforts to improve the image and quality of IUCD services (The Acquire Project 2008)[8].

**FIGURE 2: LAPM user's year 1 to year 5**

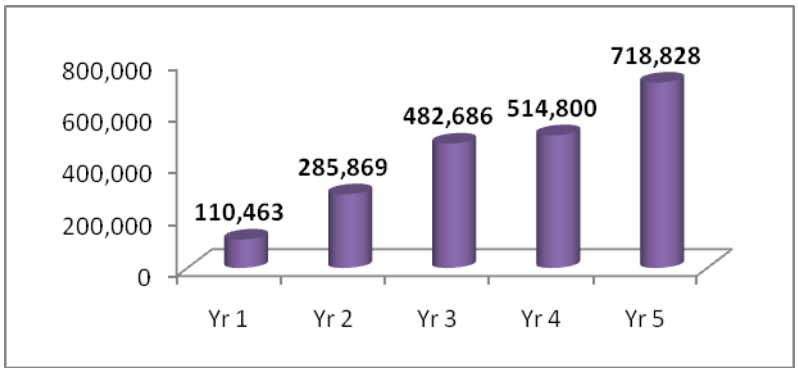
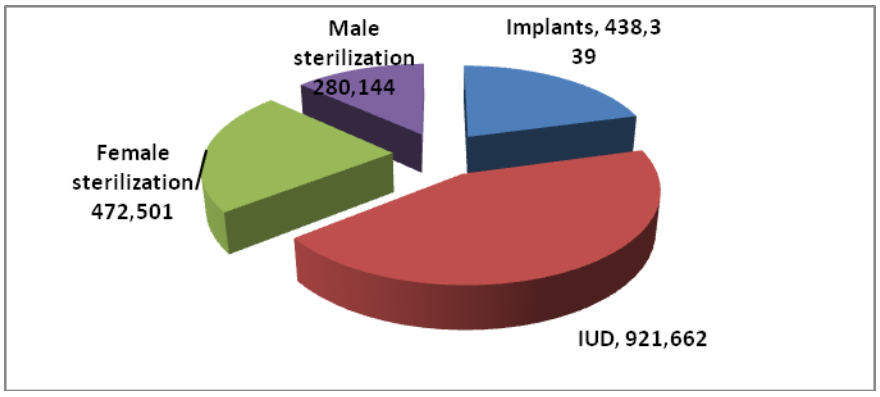



**FIGURE 3: LAPM users by type (YR 1-YR 5)**



## Annex III: Situation analysis of FP/LAPM in Kenya

Almost half (46 percent) of currently married Kenyan women are using some form of contraception with most of these women using modern methods (39 percent) and fewer women using traditional methods (6 percent). Majority of women aged 20-39 use injectables or pills while those aged 40-49 are more likely to use female sterilization. Condom use is highly common among sexually active unmarried women. Kenya has experienced significant decline in TFR over the last 30 years from 8.1 in the late 1970s to 4.6 in 2008-09. Although there was a decline in the TFR between the years 2003 and 2008, the decline was more significant among women in urban areas (12 percentage decline) than rural areas (4 percent decline).

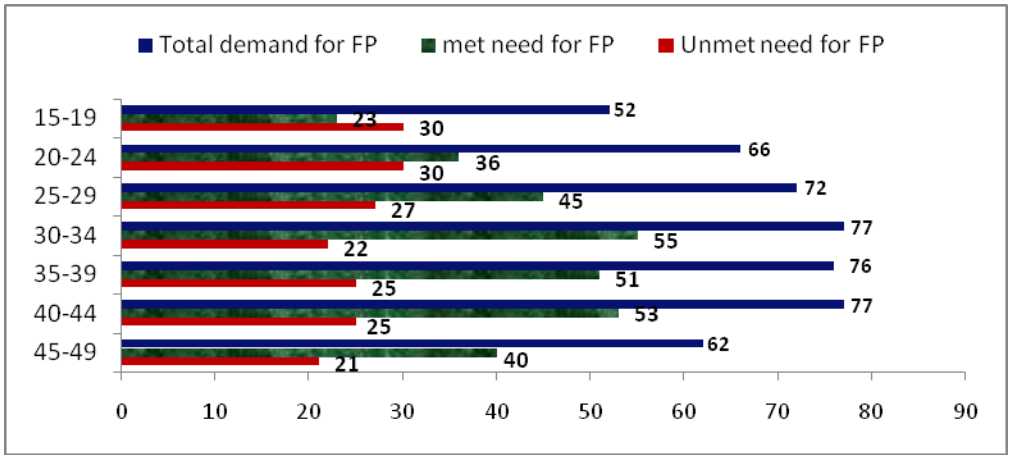
Long acting reversible methods, implants and IUCD, are the least preferred among women and their use has stagnated at 2 percent over the past five years. With regard to permanent methods, female sterilization remains least popular, being preferred by only 5 percent of currently married women. Its use over the last ten years has declined by between 1-2 percentage points. There is limited data collected by KDHS on Vasectomy.

### Potential demand for LAPM services in Kenya

The statistics show that current use of LAPM is low with figures of 5 percent or less. On the other hand, significant proportions of currently married women either do not want any more children or would wish to have another child after 2 years. With the high unmet need for family planning among currently married women (26 percent), advocating for LAPM is an opportunity that could be exploited. Unmet need is highest among women aged 15-19 and 20-24 both at 30 percent each (Figure 4).

In the application of a market approach to planning, the demand for permanent methods is generally low among women of reproductive age although 49 percent of currently married women indicate that they do not want any more children (KDHS 2008-09). In addition the demand for Vasectomy is even lower. Although the permanent method would be the best option for women who do not want any more children, women are reluctant to opt for this method. In view of this the emphasis should therefore be on long acting, reversible methods; an area with more demand given the number of women who want to delay pregnancy. The provision of permanent FP methods still remains the domain of medical doctors and specialists whose training needs could be addressed as much as possible through pre-service, internship and in-service training.

**FIGURE 4: Need and demand for FP services among currently married women**




Current use of reversible long term and permanent family planning methods varies with age. IUCDs, implants and permanent methods are generally not used among women aged 15-24 but are significantly used among women within the age group 45-49 (over 10 percent).

## Constraints to providing LAPM

Inadequate health provider skills and attitudes have been documented as major barriers to the provision of LAPMs. Attitudes may affect how providers counsel their clients about LAPMs and in some instances, clients visiting a health facility for a family planning method have reported not being informed about long term methods such as IUD, BTL and vasectomy by health care providers (DRH/MOPHS 2008)[9]. Other concerns health care providers have is the association between IUCDs and pelvic infections.

Cost barriers may hinder policy makers and program managers from making LAPM part of the contraceptive method mix. This results into constant stock outs of the commodities, equipments and supplies and hence less training opportunities for health service providers (FHI 2007a). An important point to make is that although the initial investment in LAPMs is high it is cost saving in the long run.

## Community members' perceptions of LAPMs

Despite the advantages outlined for LAPMs there is a general decline in use in Kenya and some of the reasons could be limitations in health personnel, inadequate information over the benefits and advantages, the myths and misconceptions among clients, provider bias and a working public-private partnership.

The drop in IUCD utilization is based on the fear of HIV infection, poor product image, provider bias, deteriorating skills, shifting client preferences and the decline in the health infrastructure (FHI, MOH/Kenya 2005, MOH Kenya 2008)

While majority of community members are aware of the different family planning choices available, including LAPM, their use is clouded by the perceptions they have towards these methods. Results from focus group discussions conducted with community members from Meru, Kirinyaga and Laikipia districts indicate that both men and women believe that some contraceptive methods such as female sterilization, the injection and vasectomy interfere with one's sexual desire / libido (DRH/WHO, 2010)[10].

**Social Franchising and marketing of family planning**

A social franchise encompasses a network of private health practitioners linked through contracts to provide socially beneficial services under a common brand. Social franchising offers a way of improving accessibility and quality to a wide range of health services using private service providers. Nearly two decades of evidence exists to demonstrate the effectiveness of social franchising as a platform for service delivery in developing countries. The number of social franchises has doubled every four years since 1994 with majority (86%) of clients being in South Asia. A wide range of health services are covered by these schemes with family planning taking the lead in 90% of the franchises[11]. In Kenya there are two social franchises with a focus on family planning; Tunza Family Health Network and DRH/AMUA franchise.

Other innovative approaches to expand access to FP methods include RH-output based approach using voucher system managed by DRH/KfW and training of community midwives in long acting FP DRH /Population council.

## Annex IV: Health Sector's Efforts towards Increasing Utilization of FP/LAPM

The Ministry of Public Health and Sanitation has doubled its efforts towards increasing access to utilization of LAPMs as one of the ways of expanding access to family planning services. To this effect several strategic documents have been developed and include the following:

- Vision 2030 where family planning is within the social pillar
- National Reproductive Health Policy 2007
- The National Reproductive Health Strategy 2009-2015
- Contraceptive Commodities Security Strategy
- Kenya Comparative Assessment of Long Acting and Permanent Methods Activities (December 2008)
- Strategy for improving the uptake of Long Acting and Permanent Methods of Contraception in the family planning programme (July 2008-June 2010)
- Community Strategy
- Community Health Worker training Manual (*have modules on FP and provides an opportunity to include a module for CHWs to motivate women/community regarding LAPMs and referral)*
- IUD Guidelines for Family Planning Service Programmes. Course Notebook for Trainers. Jhpiego 2006
- Reproductive Health Training Standards 2008
- Situation Analysis of Family planning at Community Level, FHI 2011
- Performance needs Assessment for Health Workers- Capacity project/USAID 2010
- Managing population to achieve Kenya's Vision 2030: Plan of Action
- Draft Population Policy (2011-2030)

Acknowledging the challenges in commodity security, the Government and Donor commitments set out to procure all contraceptive needs for 2008/2009 and 2009/2010; following national Forecasting and Quantification exercises. Currently there is regular review of forecasted quantities according to changing scenarios and constant monitoring of the

contraceptive pipeline both upstream and downstream. This is evident in increased SDP reporting rates from 10% in Dec 2008 to 68% in Dec 2009.

In an effort to revitalize the use of LAPM, the National Reproductive Health Strategy 2009-2012, outlines key activities that need to be undertaken in order to promote a complete method-mix of contraceptive methods. This includes;

> *"Building the capacity of service providers to provide appropriate methods, while strengthening the health infrastructure in order to increase access and quality in the provision of a balanced method mix"(MOPHS and MOMS, 2009[12])*

## Training in LAPMs service provision

A key aspect in provision on FP and particularly the revitalization of LAPMs is skills building through training of health service providers. Training is provided at two levels: during the pre-service period and as an in-service course. Training addresses the human resource capacity so that health care providers are able to effectively and with competency perform the procedures related to the provision of FP/LAPMs.

### *Pre-service Training*

Pre-service training provides an opportunity to impart appropriate skills to a large number of service providers at the various levels of service delivery in the most cost effective way. Pre-service training therefore has the task of preparing health care providers enter into professional practice. Pre-service training often involves three levels/cadres: nurses, clinical officers and medical officers (MOs). The focus is on ensuring that all health care providers graduate from medical training institutions with the basic skills / competencies needed for effective service delivery.

The MTC produces the second largest cadre of service providers, who often manage health facilities nationally. Family planning is part of the training curriculum of nurses at both diploma and degree levels where it is allocated a total of 18 hrs and 45 hrs respectively. For the nursing degree programme there is need to refocus the time allocated for more practical skills. At the post-diploma level the clinical officer trainees cover LAPMs but the numbers trained are very few to cater for the large population.

However, training at pre-service faces several constraints. In the performance needs assessment draft report; clinical instructors expressed the views that: students are deficient in certain technical areas, are *"indisciplined"* and lack learning objectives to inform the clinical rotation. On their part clinical workload prevents them from supervising students effectively. The poor linkage between clinical instructors and training institutions' faculty members is a concern which ultimately affects overall health service provider training.

*"This has been a challenge as it seems students come to the practical area without an objective, at the end they only learn what we do every day not the objectives they had."*Clinical instructor (PNA draft report, Capacity project, 2010)

On the other hand students expressed concern over inadequate support available during clinical rotations. Students expressed concerns related to the imbalance between theory and practice during the practicum, insufficient resources in practicum sites, limited direction and guidance during the clinical rotation, physical and post-exposure prophylaxis (PEP), safety challenges, and hostility from staff toward students.

*"There are no clinical instructors available during night duties and yet the students are expected to take care of the patients."MTC student*

**Challenges of LAPM training during pre-service training**

- Short contact time allocated to LAPM by training colleges
- There has been an increase in student enrollment in medical colleges without institutional and infrastructural expansion
- Use of anatomical models and audio-visual aids is limited
- Lack of supervision during practical sessions and follow-up after graduation
- Limited exposure to practical skills of permanent methods by medical doctor interns
- Lack of standardized training material for medical training colleges

***In-service training***

In-service training remains a major source of continuous professional development for health care providers. It is the process where health professionals in service receive targeted job-related training which provides them with additional knowledge and skills necessary for them to carry out new job functions or improve performance. In-service training also updates service providers on emerging health issues, new technologies or skills that are evidence-based, as a way of improving performance and efficiency.

As the skills needed to provide FP/LAPMs are not adequately covered during pre-service training, majority of service providers receive these skills during in-service training. These include procedures such as insertion and removal of IUCDs, implants; performing BTL and vasectomy.

Several development partners in collaboration with local and international NGOs provide both financial and technical support during in-service training for health service providers in the different components of reproductive health. These include USAID through FHI, JHPIEGO, Pathfinder and Engender health. With regards to FP/LAPM Engender Health as well as FHI have been instrumental in service provider training and health facility infrastructural development

**Challenges of LAPM training during in-service training**

- Cost of the training especially self-sponsored students of the RH course.
- Lack of financial resources for the running of the DTCs.
- Limited infrastructure at the DTCs such as space.
- Lack of skills laboratories at the DTCs.
- Lack clinical training skills for preceptors at the clinical sites
- Lack of support supervision for the trainees especially for follow-and for OJT.
- Duration of the comprehensive RH course especially for private practitioners.
- Lack of awareness of service providers of the availability of the DTC.
- Erratic supply of contraceptive commodities including Long Acting Methods
- Reliance on donor funding for expendables and in-service training

**Integrating FP/LAPM provision with other services**

Integration of services can have a positive impact on client satisfaction, improve access to services and may reduce stigma associated with specific type of vertical services. Integration of HIV testing into FP/RH care has been shown to be feasible and cost-effective (Church & Mayhew 2009)[13]. Other areas where there is potential for integration with FP/LAPM service delivery settings include cervical cancer screening using cheap and cost-effective innovations such as visual inspection. Youth friendly centers may also present an opportunity for provision of some aspects of FP/LAPM services.

Provision of FP/LAPM services presents a window of opportunity for screening women for cervical cancer using safe, easy to perform and cost effective interventions like VIA/VILI. This training plan places emphasis on cervical cancer screening for women in need of FP/LAPM and more so those requiring IUCD insertion.

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