

## Impact on Family Planning and Other Reproductive Health Programming

### Background and Strategy

Access to quality FP and other RH information and services remains limited in many developing countries. Challenges include insufficient or nonexistent health workers, cadres that are poorly prepared to provide information and services and work environments that discourage undertaking FP/RH tasks. Weak infrastructure and distribution systems complicate access to FP services, especially in the poorest and most rural areas. Government health care outlets are often few and inadequately dispersed, and private-sector services are more likely to be found in areas with higher economic opportunities. Mechanisms for tracking the currency of health workers' skills as well as for retraining and supportive supervision are often lacking, along with appropriate supplies and equipment to meet the needs of clients. Workplace planning for FP service provision, alignment, development and support is often inadequate, but is essential to address FP/RH needs and is directly linked to improved service delivery.

The Capacity Project's strategic approach to FP in the area of workforce planning and leadership was to support ministries of health and other stakeholders to align their national FP workforce with their national FP priorities. This involved a range of activities such as assessing the current FP/RH workforce and its distribution (Tanzania), developing HRH strategic plans that include FP projections and solutions, developing and sharing HRH planning software to support data-driven national-level planning (numerous countries), supporting workforce task shifting (Mali) and encouraging a wide range of FP stakeholders to work together to prioritize and implement national FP workforce strengthening initiatives (Kenya, Rwanda).

In the area of workforce development, the Project's strategic approach to FP was to work at the national and global levels to strengthen FP education and training. At the national level, the Project worked with ministries of health and other key stakeholders to improve the FP skills and knowledge of the health workforce by strengthening national systems that support pre-service education, in-service training and professional associations. The strategy involved facilitating national stakeholder groups to meet and discuss FP training priorities (Mali, Rwanda, Kenya); developing national FP training plans that link pre-service and in-service training and guide future training (Rwanda, Kenya); strengthening skills of tutors to transfer FP skills and knowledge (Tanzania, Mali, Uganda, Kenya, Rwanda); providing materials and equipment to strengthen clinical practice sites (Rwanda); and strengthening the FP component of national pre-service and in-service training curricula (Mali, Rwanda, Kenya), including integrating FP into HIV service strengthening training (Rwanda, Ethiopia, Namibia). The Project used performance-based approaches to curriculum development and encouraged the inclusion of the three Healthy Timing and Spacing of Pregnancy messages (Rwanda, Mali, Tanzania, Uganda, Kenya).

Having inadequate numbers or the wrong skill mix of health workers at the service delivery level severely curtails or eliminates FP/RH work. As one group of HRH managers noted, "When the system is stressed through a lack of sufficient health care worker coverage, only

emergencies get treated.” The Project’s strategic approach to FP in the area of workforce performance support was to create conditions in which performance and productivity are optimized, qualified health workers remain in the workforce and there is a greater likelihood that critical FP/RH services will be provided and integrated. To create these conditions, the Project implemented a broad array of approaches to strengthen HRM systems and worker retention strategies at the national and district levels. HRM strengthening included training key FP decision-makers in leadership and management to become more effective champions for FP (Tanzania/mainland), designing and implementing interventions to increase worker productivity (Tanzania/Zanzibar), supporting the recruitment and deployment of essential staff to fill funded RH positions (Uganda) and developing and using FP performance standards within the context of HIV care for performance support, including supportive supervision and performance improvement (Belize, Costa Rica, El Salvador, Guatemala, Nicaragua, Panama).

The Project’s strategic approach to improving FP services through HRH systems strengthening also incorporated the cross-cutting areas of global partnering, KM, gender and FBOs.

## Results

### *Kenya: National FP Training Plan*

The Project-seconded MOH staff member led the national effort to strengthen Kenya’s FP training by developing and implementing a national FP training plan. The Project drafted the plan and built stakeholder alignment, then supported the development of the FP continuing education process. The Project also strengthened the RH component of the national pre-service nursing/midwifery curriculum to improve FP-related performance of graduates. A Project secondment led the national effort to integrate updated FP/RH content into the nursing/midwifery curriculum in alignment with the new RH training plan. The Project worked with the MOH to train pre-service tutors as master trainers, who then train new hires and colleagues on FP-HIV integration in alignment with the country’s national RH training plan.

### *Rwanda: Comprehensive FP Service Strengthening*

The Project partnered with key government leaders to address a 2006 situation analysis that revealed only 15% of Rwandan health center providers were trained in FP and no facilities offered comprehensive FP services. The Project worked to make a full range of FP services, including long-acting and permanent methods and healthy timing and spacing of pregnancies, available in health facilities by providing clinical training, supportive supervision and essential informational materials and supplies. All public health facilities in the 11 districts supported by the Project now offer a full package of FP services. FP has been integrated into the pre-service education curriculum for nurses and midwives, two master trainers are deployed in each of the country’s 30 districts, 161 on-the-job trainers are rolling out training in public health facilities, and district health networks have been trained to plan, develop, implement and evaluate FP programs. Project staff used the LFP approach to adapt the national FP curriculum to an OJT training approach that can be used by all FP organizations working in Rwanda. The Project also worked with partners to develop and carryout facility-based interventions to increase male involvement in FP services. Access to up-to-date clinical FP providers at health facilities throughout



Rwanda as a result of the government's work with development partners, including the Capacity Project, has ushered in a dramatic increase in modern contraceptive prevalence among married women, from 10% in 2005 to 27% in 2007 [Ministry of Health, 2007].

### ***Rwanda: No-Scalpel Vasectomy Program***

The Project developed a vasectomy in-service training program at two hospitals in Rwanda's Gicumbi and Nyabihu Districts. Prior to the intervention, providers in the two districts had not been trained or equipped to provide vasectomies, and doctors typically received only a half-day focus on theory without practical demonstration during pre-service education. The Project trained selected physicians and nurses in the no-scalpel vasectomy (NSV) procedure and provided the surgical training equipment and supplies. After completing the training, the providers developed action plans for continuing to offer vasectomy services. Two physicians performed extra cases and became coaches. To foster sustainability, the Project trained three physicians and four nurses as trainers, who were then able to train seven physicians and ten nurses at hospitals in four other districts.

The Project supported vasectomy teams to make outreach visits from the hospitals to six health centers (three each in Nyabihu and Gicumbi Districts) that were selected based on high client demand for the service in the surrounding communities. Given the long travel times between health centers and hospitals in some districts, sending NSV teams with surgical equipment and supplies into the health centers removed a serious logistical barrier to parts of the population.

Before the program, demand for vasectomies at Shyira Hospital was very low (five requests per month) and nonexistent at Byumba Hospital. However, demand for NSV became so high that clients had to be wait-listed. During a sample taken in the two districts in August 2008, 211 clients were on the waiting list; 172 clients had undergone a vasectomy. As of June 2009, Project-trained physicians and nurses had performed 390 NSVs, 56% performed at health centers and 15% with HIV-positive clients. A major contributor to the program's success appears to be the logistical and financial support for NSV teams to work at health centers. Many potential clients do not live within easy walking distance of a hospital, so the financial and opportunity costs involved in getting an NSV remain a very real constraint. Of the respondents sampled in the client satisfaction survey, almost all (98%) reported satisfaction with the procedure.

### ***Study on Bottlenecks to Implementing Updated FP/RH Guidelines***

USAID, the United Nations Population Fund, WHO and the cooperating agency community, among others, have invested considerable effort updating and improving norms and standards for RH and FP services and training materials. Despite these efforts, there is a lack of documented evidence on the actual implementation and impact of FP/RH guidelines. The Project conducted a study on bottlenecks to implementing updated guidelines at the country level and contributed to the FP Training Resource Package website. A primary finding is that efforts limited to dissemination of norms and standards alone, reliance on training alone or even more frequent supervision alone will be insufficient to change practices at the clinic

*"We have to acknowledge the Capacity Project as a real champion, especially in strengthening the capabilities of family planning providers. This has improved the quality of services offered, which brought about the public's acceptance."*

—Dr. Camille Manyangabe, government FP representative, Rwanda

*"I chose this method because my wife and I live with HIV. I am under ARVs [antiretroviral drugs] but my wife is not. Although we have been using condoms, we decided not to take the risk of pregnancy to avoid having an infected newborn. We already have three children and all of them are HIV free."*

—NSV client in Rwanda

Read *Repositioning FP: Rwanda's No-Scalpel Vasectomy Program* (available at [www.capacityproject.org](http://www.capacityproject.org)).

Read *Implementing Updated FP and RH Guidelines through Organizational Change* (available at [www.capacityproject.org](http://www.capacityproject.org)).

level. Multiple interventions are the key to impact, combining training in technical knowledge and skills with the training in human dynamic skills that empower staff to effect change in their day-to-day environment. A related paper and technical brief supplement this work.

### Lessons Learned

- Without addressing the broader HRH issues, access to key services such as FP will remain limited or unavailable.
- Countries need to align national FP workforce planning with national FP priorities.
- Strategic placement of seconded staff within ministries of health can strengthen the national FP training by mobilizing support for the development and implementation of a national FP training plan.
- Addressing logistical and financial support may be as important in increasing FP service access as information and counseling.
- There is a lack of documented evidence that increasing training materials improves the actual implementation and impact of FP/RH guidelines.

