INTEGRATED FAMILY HEALTH PROGRAM

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JANUARY 2010

A satisfied client after Implanon insertion.

photo: Mengistu Asnake, Pathfinder/Ethiopia

Scaling Up Community-Based Service Delivery of Implanon:

The Integrated Family Health Program's Experience Training Health Extension Workers

With over 77 million people, Ethiopia has the second largest population in sub-Saharan Africa and it continues to grow rapidly. Though the country's contraceptive prevalence rate grew from 8 percent in 2000 to 15 percent in 2005 and nearly 80 percent of currently-married Ethiopian women want to either stop or postpone childbearing,[1] demand for contraception has grown faster than its use. The result is an unmet need for contraception of 34 percent (20 percent for spacing, 14 percent for limiting).

Nearly 60 percent of Ethiopians live more than 10 kilometers from the nearest health facility.[2] Facilities regularly experience contraceptive shortages[3] and many facilities don't have staff trained in all family planning (FP) methods. Lack of knowledge about methods or sources of services and weak distribution systems further contribute to a lack of access to FP. Compounding the problem, more than 83 percent of Ethiopians live in rural areas,[4] many isolated and difficult to access.

In 2005, in recognition of the need to improve the country's health care delivery capacity, the Ethiopia Federal Ministry of Health (EFMOH) launched the Accelerated Expansion of Primary Health Care Coverage plan through the Health Extension Program (HEP). The program provides promotive, preventive, and select curative health care services through trained, salaried Health Extension Workers (HEWs) stationed in each kebele (village). The HEP reaches all segments of the population and functions within the community as the lowest level of the health system. Services provided by the HEWs include hygiene and environmental sanitation, disease prevention and control, and family health. The HEWs use health education and communication as a cross-cutting approach to address these concerns with their communities.

The HEP has made great progress in educating women about the benefits of FP, but despite their safety, efficacy, and low cost, access to long-acting methods of family planning (LAFP) has remained scarce at the community level. To address this issue, the EFMOH invited four organizations to implement pilot programs designed to improve availability of LAFP.

The Integrated Family Health Program (IFHP), a partnership between Pathfinder International and John Snow, Inc., was asked to train HEWs in Implanon insertion in eight woredas

The Integrated Family Health Program (IFHP) is a five-year USAID-funded program led by Pathfinder International and John Snow, Inc., in collaboration with the Consortium of Reproductive Health Associations and the Academy for Educational Development. IFHP supports the government of Ethiopia to promote an integrated model for strengthening maternal child health, family planning, and reproductive health services for rural and hard-to-reach populations in four regions of Ethiopia (Oromiya, Tigray, SNNP and Amhara).

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[1] Central Statistical Agency [Ethiopia] and ORC Macro. 2006. *Ethiopia Demographic and Health Survey 2005.* Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ORC Macro.

[2] Central Statistical Agency of Ethiopia. *Households distance in km to the nearest health service, health center, year 2004.* Available online: http://www.csa.gov.et/pdf/Basic_welfare_Indicator/Households_distance.xls.

[3] Ashford, Lori. *Unmet Need for Family Planning: Recent Trends and Their Implications for Programs*; Measure Communication (2003) p2.

[4] Health Extension Program in Ethiopia: Profile. Health Extension and Education Center, Federal Ministry of Health, Addis Ababa, Ethiopia. June 2007, p. 2.

An HEW practices Implanon insertion on an arm model.

photo: Mengistu Asnake, Pathfinder/Ethiopia

(districts) of the Amhara, Oromia, SNNP, and Tigrai regions using a service-delivery based training model developed by Pathfinder in 2004 for use with nurses, health officers, and physicians. By training HEWs in Implanon insertion, the IFHP provides quality LAFP services at the community level to thousands of women who previously would not have had access to these services.

Preparation for Training

To cultivate government buy-in and ownership of the program, the IFHP engaged government stakeholders at each step of the process. Woreda health offices helped identify HEW supervisors, clinic providers, and HEWs for training. Obstetricians and gynecologists, who had participated in the national training of trainers (TOT) for Implanon insertion and had experience training clinical providers in LAFP, were chosen to serve as master trainers. In consultation with the EFMOH and other partners, the IFHP prepared a training curriculum, educational materials, and monitoring and evaluation tools for the project rollout.

To address a shortage of anatomical arm models for use during the clinical practicum sessions, IFHP staff designed an innovative substitute created from wood, cotton, and a piece of inner tube from a car tire. The low-cost models were produced by a local furniture shop and were shared with organizations implementing the training in other regions.

Because one of the biggest challenges in implementing LAFP training sessions is identifying enough clients for the practicum sessions, the IFHP used its audio-visual vans for community mobilization activities to create awareness and inform clients of when and where services would be available. Voluntary Community Health Workers assisted in informing and mobilizing communities. As a result of these efforts, more than 3,500 women turned out for the training events, resulting in more than 7,000 couple years protection.

Training of Trainers

In mid-July 2009, one TOT session was conducted in each of the four regions. The 72 participants included clinical providers previously trained in Norplant, Jadelle, and IUD insertion, and HEW supervisors. Each five-day training session included two days of theoretical sessions and three days of clinical practicum. The sessions emphasized both training techniques and mastery of the technical skills necessary for FP counseling and Implanon insertion (see Table 1).

TABLE 1: DISTRIBUTION OF TOT PARTICIPANTS BY REGION AND GENDER

			TOT PARTICIPANTS			
					TOTAL	
REGION	ZONES	WOREDAS	HEW SUPERVISORS	CLINICAL PROVIDERS	M	F
Amhara	2	2	13	4	11	6
Oromia	2	2	12	2	12	2
SNNP	1	2	9	9	13	5
Tigrai	2	2	15	8	14	9
Total	**7**	**8**	**49**	**23**	**50**	**22**

The availability of previously-trained clinical providers meant that methods other than Implanon, such as Jadelle, Norplant, and IUDs, were available to clients during the clinical practicum. As shown in Table 2, a total of 885 clients were served during the TOT and each TOT participant was able to serve an average of 12 clients.

The training ratio was one trainer to every four trainees. During the clinical practicum, trainers observed trainees' skills in initial client counseling, preparation of materials with attention to infection prevention, insertion procedures, and post-insertion client counseling. The trainers provided immediate feedback to individual trainees and group feedback during daily evaluation of the training. Participants also reviewed the training approaches and the preparation needed to implement the rollout training. Upon completion of the course, the trainees were provided with the materials necessary to conduct the rollout training sessions.

Woredas Selected for Implementation

In consultation with the EFMOH, the following woredas were selected for implementation:

Amhara Region
East Gojjam Zone—Kuye Woreda
South Gondar Zone—East Este Woreda

Oromia Region
North Shoa Zone—Werejarso Woreda
Arsi Zone—Munesa Woreda

SNNP Region
Wolayeta Zone—Bolososore Woreda
Wolayeta Zone—Damotgale Woreda

Tigrai Region
Southern Tigrai Zone—Ofla Woreda
Eastern Tigrai Zone—Tsasitsetsamba Woreda

Rollout Training

With supervision from the master trainers, the HEW supervisors and clinical providers held the rollout training sessions for 218 HEWs, averaging 27 HEWs per woreda. Using the training curriculum developed by the IFHP and partners, the training focused on FP updates, infection prevention, an overview of LAFP—including mechanism of action, effectiveness, side effects and complications, medical eligibility, screening,

TABLE 2: FP SERVICES PROVIDED DURING THE TOT BY REGION

	TYPE OF FP SERVICES PROVIDED										
	IMPLANON		JADELLE		NORPLANT		IUD		PILLS	DEPO	TOTAL
REGION	I*	R	I	R	I	R	I	R			
Amhara	190	—	140	1	—	3	3	—	—	—	**337**
Oromia	92	—	8	—	—	—	—	—	7	11	**118**
SNNP	332	—	19	—	—	5	—	—	—	—	**356**
Tigrai	64	—	7	—	—	—	—	—	—	3	**74**
Total	**678**	**—**	**174**	**1**	**—**	**8****	**3**	**—**	**7**	**14**	**885**

TABLE 3: FP SERVICES PROVIDED DURING THE ROLLOUT TRAINING BY REGION

	TYPE OF FP SERVICES PROVIDED										
	IMPLANON		JADELLE		NORPLANT		IUD		PILLS	DEPO	TOTAL
REGION	I*	R	I	R	I	R	I	R			
Amhara	852	—	258	—	—	—	1	—	—	—	**1111**
Oromia	479	—	—	—	—	—	—	—	—	—	**479**
SNNP	651	—	—	—	—	8	—	—	2	15	**676**
Tigrai	432	—	55	—	—	—	—	—	—	3	**490**
Total	**2414**	**—**	**313**	**—**	**—**	**8****	**1**	**—**	**2**	**18**	**2756**

* I=Insertion, R= Removal ** The majority of Norplant removals were performed for women who had used it for five years or longer. In some cases Implanon was inserted after the Norplant removal.

Left: Women await services outside a clinic. The demand for services is ofttern greater than providers can accommodate in a day. **Right:** An HEW counsels a client on her contraceptive choices. Informed clients are more likely to continue using the contraceptive method of their choice.

photo: Mengistu Asnake, Pathfinder/Ethiopia

and post-insertion counseling—Implanon insertion and removal techniques, and basic FP counseling. Like the TOT, the training consisted of two days of theoretical training and three days of clinical practicum. Pre- and post-tests were given to determine gains in knowledge. During the competency-based training, all trainees became proficient at inserting Implanon on anatomical arm models before moving on to live patients. Proficiency was determined through use of a competency-based checklist.

As shown in Table 3, nearly 2,800 clients were provided with the contraceptive method of their choice during the clinical practicum. To ensure proper counseling, the HEWs used a simple checklist for excluding pregnancy that had been widely used in the past by Voluntary Community Health Workers. Each HEW was able to perform an average of 11 Implanon insertions and by the end of the training each HEW was deemed competent to perform insertions at their health posts without supervision.

A delay in holding the rollout training in Oromia meant that it was held during the middle of the rainy season, which affected the community mobilization activities and clients' transportation to the training site. Turnout in Oromia was therefore much smaller than in other regions, thus highlighting the importance of the community mobilization aspect of the model.

Once certified, each HEW was provided with 20 sets of Implanon and other consumable materials needed to continue routine services. In addition, materials needed for other LAFP methods not available at health posts, such as Jadelle and IUDs, were provided to the referral health centers. The HEW supervisors and woreda health offices are responsible for refilling commodity supplies and the IFHP helps fill gaps in supplies during follow up visits.

Post-Training Follow Up

Two months after the initial training, a review meeting was held in each region with the trainers and HEWs to discuss their progress, challenges, and the way forward.

In the two months since the training, the HEWs provided more than 4,500 Implanon insertions (Table 4). The HEWs reported no major challenges in implementation and the few clients who returned for minor side

effects required only counseling and reassurance by the HEWs. There were no cases that required removal of the implant. To ensure quality of services, the master trainers also observed HEWs performing Implanon insertions in selected health posts in each woreda and IFHP staff are visiting selected health posts for follow-up supervision. In a few cases, the IFHP made arrangements with the woreda health offices to restock health posts when supplies of Implanon and related consumables ran low.

TABLE 4: NUMBER OF CLIENTS SERVED WITH IMPLANON BY HEWS DURING THE FIRST TWO MONTHS AFTER INITIAL TRAINING

REGION	NUMBER OF HEWS	TOTAL CLIENTS SERVED WITH IMPLANON	MEAN NO. OF CLIENTS SERVED PER HEW
Amhara	54	1448	27
Oromia	59	1215	21
SNNP	59	1360	23
Tigrai	46	565	12
Total	**218**	**4588**	**21**

Conclusion

The project clearly showed that there is great demand for LAFP services at the community level and that HEWs can effectively meet this need. Provision of LAFP services at health posts increases the number of users and addresses unmet need by reducing transportation, geographical, and knowledge barriers to service. With proper follow up and technical support, HEWs are technically capable of managing Implanon insertion without difficulty, as was demonstrated during the clinical practicum and follow-up. However, with proper counseling, clients demand methods beyond Implanon, which requires thorough planning to make a wide variety of methods available for all clients during the training sessions.

Because project rollout was implemented quickly to avoid the rainy season, the level of involvement of the regional health bureaus, zonal health departments, and woreda health offices was limited. Although the public sector participation was encouraging at some levels, sustaining these activities on a wider scale will require greater ownership by the government health sector. The partners' input alone will not be enough to scale up implementation and coverage.

Future trainings should prepare more materials in the local languages and may need to build in more time for both classroom and clinical practicum. Some of the theoretical sessions had to be cut short due to time constraints and trainees had a limited amount of time to practice on the anatomical arm models. Trainees found the improvised arm model difficult to penetrate, but this meant that they were well prepared and found the procedure much easier to execute on actual clients.

Though the overall cost of the insertion was low, fees were charged for some diagnostic services and consumables during the clinical practicum. This was an unexpected cost for the clients who expect FP services to be free at the health center level. This cost could act as a deterrent and future trainings should look at ways to waive these fees.

Because these events attract such a large number of clients, the IFHP is looking for ways to expand the information and services delivered at each session. During the clinical practicum, a significant number of clients came to the facilities with children under five and other family members. These sessions could therefore be used as an opportunity to integrate other maternal and child health services such as immunization, growth monitoring, and educational activities.

Between October 2009 and September 2010, the IFHP will scale up the Implanon training for HEWs to an additional 43 woredas across the four project regions and will continue to support the original eight woredas with follow up and technical support. The IFHP is also developing an operational research study to document patterns of Implanon use and discontinuation rates. The results of this study will inform scale up of similar initiatives within Ethiopia and in other countries that can benefit from community level LAFP service delivery.

A group of HEWs watches a film on infection prevention during the rollout training.

photo: Mengistu Asnake, Pathfinder/Ethiopia

Steps to LAFP Service-Delivery Based Training

1. Consultation between IFHP and EFMOH to identify implementation areas
2. Consultation with woreda health offices to identify HEW supervisors, clinic providers, and HEWs for training, and Ob/Gyns master trainers
3. Preparation of curriculum and training materials
4. Community mobilization activities to announce the service provision dates and create demand for the services
5. TOT, including theoretical and practical sessions
6. Rollout raining, including theoretical and practical sessions
7. Provision of supplies to health posts
8. Review meeting and on-the-job supervision

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