



**Ministry of
Community Development
Mother and Child Health**

**A RAPID ASSESSMENT OF LONG ACTING
FAMILY PLANNING TRAINING OF
HEALTHCARE PROVIDERS**

MAY 2014

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
BP	Blood Pressure
CPR	Contraceptive Prevalence Rate
C Rings	Cervical Rings
DMPA	Depot Medroxyprogesterone Acetate
FHI	Family Health International
FP	Family Planning
HIV	Human Immunodeficiency Virus
IEC	Information Education and Communication
IUD	Intrauterine Device
IUCD	Intrauterine Contraceptive Device
LAFP	Long Acting Family Planning
LMIC	Low and Middle Income Country
MCDMCH	Ministry of Community Development Mother and Child Health
MNCH	Maternal and Neonatal Child Health
MOH	Ministry of Health
PID	Pelvic Inflammatory Disease
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
PPAZ	Planned Parenthood Association of Zambia
SPSS	Statistical Package for Social Sciences
STI	Sexually Transmitted Infection
TBL	Tubal Ligation
TFR	Total Fertility Rate
TG-RAR	Technical Guide to Rapid Assessment and Response
USAID	United States Agency for International Development
WHO	World Health Organization
ZDHS	Zambia Demographic Health Survey
ZISSP	Zambia Integrated Systems Strengthening Programme

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Executive Summary

The Ministry of Health (MOH) and the Ministry of Community Development Mother and Child Health (MCDMCH), with support from Zambia Integrated Systems Strengthening Programme (ZISSP), conducted in-service training from 2010 to 2012 aimed at improving knowledge, skills and attitudes in Long-Acting Family Planning (LAFP) services for health workers. The over-arching objective of this assessment, “A Rapid Assessment of Long Acting Family Planning (LAFP) Training of Healthcare Providers”, was to assess the retention and application of knowledge, skills and attitudes in LAFP services for trained health workers.

The assessment methodology was comprised of interviews with 49 trained healthcare providers and 40 supervisors from 40 selected health facilities using a semi-structured questionnaire measuring knowledge, attitude and practices.. The assessment had three main limitations. First, only 79% of the actual sample size was achieved because some of the healthcare workers were not found at the health facility at the time of the study. Second, the assessment used convenience sampling as a sampling strategy (sampling only those facilities with health providers trained with ZISSP support); therefore the findings cannot be generalized to all health facilities which provide LAFP. Finally, respondents may have had recall gaps given the time lapse between their participation in the training and the rapid assessment.

The report documents the following key findings:

1. Knowledge levels were high among the respondents concerning contraceptive choice, mechanism of action, side effects and contraindications of intrauterine contraceptive devices (IUCDs) and Jadelle.
2. The application of the skills was found to be generally high, but experience with insertion of Jadelle was found to be higher (96%) compared to insertion of IUCDs (30%) by trained providers. Barriers to applying skills were lack of supplies (only 29% of centres had IUCDs available) and equipment (e.g., for infection control, insertion and removals).
3. The healthcare providers’ attitudes towards LAFP were found to be positive, and there was a demonstrable increase in utilization of LAFP services after training. Ninety eight per cent of the healthcare providers claimed that LAFP services had increased because they were able to provide the LAFP methods after training.
4. Supervisors rated the healthcare providers highly, based on the providers having the right attitude towards LAFP; exhibiting professional behaviour towards LAFP; demonstrating correct and necessary capability and skills.
5. Ninety-eight per cent of the trained healthcare providers claimed that there is integration of HIV services with FP services, mainly with HIV counselling and testing and Prevention of Mother to Child Transmission (PMTCT) services.

The findings clearly show that the LAFP trainings have had a positive impact on LAFP service provision at facilities where trained healthcare providers are stationed and providing LAFP services. The report makes the following recommendations:

- Scale up LAFP training, accompanied by mentorship, to more health providers and more facilities in order to increase access to and use of LAFP methods.
- Strengthen logistics systems for LAFP commodities, such as IUCDs.
- Ensure that health facilities have the necessary equipment to provide LAFP.
- Increase opportunities for health providers to receive specific training and in-service mentorship on the importance of record keeping.

CHAPTER 1: INTRODUCTION

1. Background

In Sub-Saharan Africa only 21% of women use modern methods of contraception and the fertility rate is high¹. Factors contributing to high fertility include low education levels, desire for large families, high levels of infant and child mortality and low levels of family planning (FP) knowledge and use.

In Zambia, the Contraceptive Prevalence Rate (CPR) for modern methods is 42% (urban) and 28% (rural). The Total Fertility Rate (TFR) in Zambia stands at 6.2 births per woman of reproductive age (urban 4.3, rural 7.5), which is a higher rate than most countries in the east and southern African region². Zambia is also characterized by a high unmet need for FP; 27% of all married women report having an unmet need³, meaning that the woman is at risk of unwanted pregnancy and not using contraceptives. In addition, the use of modern FP methods is low, and the use of long-term contraceptives methods is especially low. Less than 1% of married women use intrauterine contraceptive devices (IUCDs) or implants⁴.

One way to address low rate of contraceptive use and high rate of unmet demand is for healthcare workers to provide FP services as close to communities as possible. However, many healthcare providers lack adequate knowledge, skills and attitudes to deliver quality FP services. Due to this capacity gap, healthcare providers are not able to appropriately counsel families on available modern FP methods and to dispel common myths that hinder possible recipients from accessing FP services.

To enhance access to FP services and increase the utilization of Long-Acting Family Planning (LAFP) methods, the Ministry of Health (MOH) with the support from Zambia Integrated Systems Strengthening Programme (ZISSP) has embarked since December 2010 on an in-service training program aimed at equipping healthcare workers, nurse tutors and clinical instructors with the necessary knowledge, skills and attitudes so that they are better positioned to deliver quality FP services. As of Dec 2012, a total of 61 nurse tutors and clinical instructors and 123 healthcare providers had been trained in counselling, screening, and offering LAFP methods. Prior to the training, ZISSP visited the health facilities to ensure that they were suitable to provide LAFP methods (e.g., sterilization capability, basic equipment for insertion and removal of Jadelle and IUCDs, privacy, etc.) Twelve-day trainings, conducted using LAFP training manuals (Jhpiego), were comprised of four-and-a-half days of classroom-based learning, followed by two-and-a-half days of demonstrations and assessments and four-and-a-half days of practicum (**Appendix I**). ZISSP conducted post-

¹ Williamson, Nancy. (2013). *UNFPA State of the World Population 2013. Motherhood in Childhood: Facing the challenge of adolescent pregnancy*. United Nations Population Fund: New York, NY, page 105.

² Central Statistical Office (CSO), Ministry of Health (MOH), Tropical Diseases Research Centre (TDRC), University of Zambia, and Macro International Inc. 2009. *Zambia Demographic and Health Survey 2007*. Calverton, Maryland, USA: CSO and Macro International Inc., page 56

³ Ibid., pages 55 & 106

⁴ Ibid, page 70

training follow-up visits to 100 training participants, assessing retention of knowledge and skills and providing on-site mentorship and technical support for 62 healthcare providers.

The MOH, Ministry of Community Development Mother and Child Health (MCDMCH) and ZISSP commissioned this rapid assessment to ascertain the knowledge, attitude and practices among healthcare providers who were trained in LAFP methods at least six months prior to the assessment.

1.1 Overarching objective

The overarching objective of the rapid assessment was to assess the retention and application of knowledge, skills and attitudes in LAFP services for trained health workers.

1.2 Specific objectives

1. To measure the extent to which healthcare providers apply the knowledge and skills acquired from the trainings to their daily service provision
2. To assess providers' attitudes to and perceptions of the LAFP services
3. To assess providers' levels of adherence to LAFP guidelines in their service provision
4. To assess the level of utilization of LAFP services
5. To assess the level of integration of LAFP services with:
 - a) Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) services, and
 - b) Male involvement in FP

CHAPTER 2: METHODODOLOGY

2. Methodological approach

This rapid assessment was a non-interventional, cross-sectional survey. Based on the stated objectives, primary data collection used a complementary survey approach, which included individual interviews with healthcare providers and their supervisors. This approach was further complemented by facility data gathered using a checklist (see **Appendix II**).

The semi-structured questionnaire was comprised of both quantitative (closed-ended) and qualitative (open-ended) research questions (see **Appendix II**). For some open-ended questions, the assessor categorized the answers through a list of pre-determined responses. Interviews were conducted with healthcare providers from the selected facilities who were trained in LAFP provision to measure their knowledge, attitudes and practices. The interviews with supervisors of healthcare providers captured their perception of the trained healthcare providers with regards to provision of LAFP services and also inquired about service delivery statistics. Service delivery statistics were then verified through a record review to collect any available data on LAFP service provision within the last 12 months.

The authors also conducted a literature review of similar studies to set the findings from the Zambia LAFP assessment in context for the basis of discussion.

2.1 Inclusion and exclusion criteria

The study population consisted of healthcare providers that were trained in LAFP by MOH, with technical and financial support from ZISSP, at least six months prior to the assessment. Healthcare providers that received other LAFP training were still eligible for inclusion. The study population excluded nurse tutors and clinical instructors as the study focused on healthcare workers who provide LAFP services as part of their daily work.

2.2 Sampling and survey location

At the time of the survey, the MOH had completed LAFP training in eight provinces (out of ten) and in 23 districts (out of 89), and the number of people trained in LAFP varied from one district to the other. Also, the selection for training for LAFP was dependent on the facility's capability to provide LAFP services (e.g., sterilization capability, availability of basic equipment for insertion and removal of Jadelle and IUCDs, privacy, etc.) and on the presence of an eligible cadre of health worker for LAFP training (prioritizing nurses and midwives, although clinic officers and doctors were also eligible).

Based on these factors, the rapid assessment used a three-stage sampling design. First, to maximize the number of targeted respondents who could be interviewed within the specified data collection period, provinces with trained healthcare workers were purposively selected. This stage resulted in selection of three provinces (Eastern, Southern and Central) out of the

eight provinces with trained healthcare workers. At the second stage, districts from the three provinces were selected based on high numbers of facilities with trained healthcare providers. This second stage resulted in selection of 11 districts. In the third stage, health centres were selected from the 11 districts based on high numbers of trained health care workers. A total of 42 health centres were selected. (A list of the selected districts and facilities can be found in **Appendix III.**)

Because the rapid assessment was meant to ascertain the extent to which healthcare providers trained in LAFP were applying what they learned during the trainings, only specific healthcare providers at the 42 health centres were eligible for interviews (see criteria in section 2.1, above). The rapid assessment used a list of healthcare providers trained in LAFP as the sampling frame. A total of 130 trained healthcare providers from eight provinces were eligible to be included in the survey. Because only three provinces were included in the rapid assessment survey, the target population sample was limited to the 67 healthcare providers trained from these three provinces.

Using EpiInfo Version 6, of the total target population of 67, the expected chances of finding trained healthcare at the respective facilities was put at 90% and the worst case scenario at 85%. This provided a minimum sample size of 45 with 95% confidence levels and +/-5 margin of error.

2.3 Data Quality

2.3.1 Fieldwork Procedure

1. At least two interviewers, accompanied by a team member in a supervisory role, visited the selected health centres (**Appendix IV**).
2. Before the questionnaire was administered, consent was obtained from each participant (healthcare providers and their respective supervisors).
3. Immediately after the interviews, the research supervisor checked the questionnaires for accuracy, consistency and completeness.
4. A checklist was used to collect facility-based data from the facility records on specific FP indicators.

2.3.2 Data Entry and Analysis

1. The questionnaires were cleaned before being entered, and data cleaning was continued throughout the process of data entry.
2. Data was coded and entered into SPSS before analysis.

2.4 Survey limitations

1. The rapid assessment used *convenience sampling* as the sampling strategy, which could have resulted in selection bias. This bias may not allow the generalization of the results to all the facilities which provide LAFP.
2. The actual achieved sample size was less than the proposed total target population sample of 67 because some of the healthcare workers were not found at the health facility at the time of the study (e.g., due to providers transferred to another facility or away from the station on the day of the visit). However, this did not affect the survey findings because the 49 persons interviewed exceeded the 45 person minimum sample size, thereby maintaining a 95% confidence levels and +/-5 margin of error.
3. The participants completed training six or more months prior to the assessment, a time period which could contribute to recall bias of key information presented at the training.

CHAPTER 3: SURVEY FINDINGS

3.0 Introduction

The first section of this chapter, section 3.1, describes the demographic characteristics of the respondents (i.e. healthcare providers and their supervisors). Section 3.2 discusses the provision of FP services. This is followed by the section 3.3, which presents findings on the knowledge about and experience with LAFP by trained healthcare workers, with specific focus on IUCDs and Jadelle. Section 3.4 discusses supervisors' views on staff providing LAFP. Sections 3.5 and 3.6 present health workers' attitudes and perceptions on LAFP and utilization of LAFP services. Section 3.7 presents findings about health facility capabilities in providing LAFP services, and finally, section 3.8 discusses the degree of integration of HIV and AIDS services and male involvement into LAFP provision.

3.1 Survey Demographics

3.1.1 Healthcare providers

A total of 49 healthcare providers were interviewed for the rapid assessment survey. Of the 49 respondents, 11 were male (22%) and 38 female (78%). The mean age of the respondents was 41, as was the median. The majority of the respondents were in the age range of 40 - 49 years old while the youngest was less than 30 years old. The majority (61%) of the healthcare workers who were trained were enrolled midwives followed by those who were enrolled nurses (18%).

The majority (55%) of the respondents had been working at the health facility for at least three years. Half of the respondents had been providing LAFP services between one and two years (51%) followed by those who had been providing the services for less than one year (35%). The experience of providing LAFP among respondents ranged from seven months to eight years. The mean was just short of two years. The background characteristics of provider respondents are shown in **Table 1** below.

Table 1: Background Characteristics of healthcare provider respondents

Background Characteristic	N	Per cent
Sex		
Male	11	22.4
Female	38	77.6
Age (years)		
20-29	2	4.1
30-39	18	36.7
40-49	20	40.8
50-59	9	18.4
Principal profession		
Registered Midwife	4	8.2
Registered Nurse	3	6.1
Enrolled Midwife	30	61.2
Enrolled Nurse	9	18.4
Medical Doctor	3	6.1
Number of years worked at the facility		
Less than 1 year	9	18.4
1 - 2 years	13	26.5
3 - 4 years	13	26.5
5 years and over	14	28.6
Number of years providing LAFP services		
Less than 1 year	17	34.7
1 - 2 years	25	51
3 - 4 years	6	12.2
5 years and over	1	2

The majority of respondents had received at least one training in LAFP from ZISSP (87.8%) while a few had been trained by another agency (8.2%, n=4).

3.1.2 Healthcare supervisors

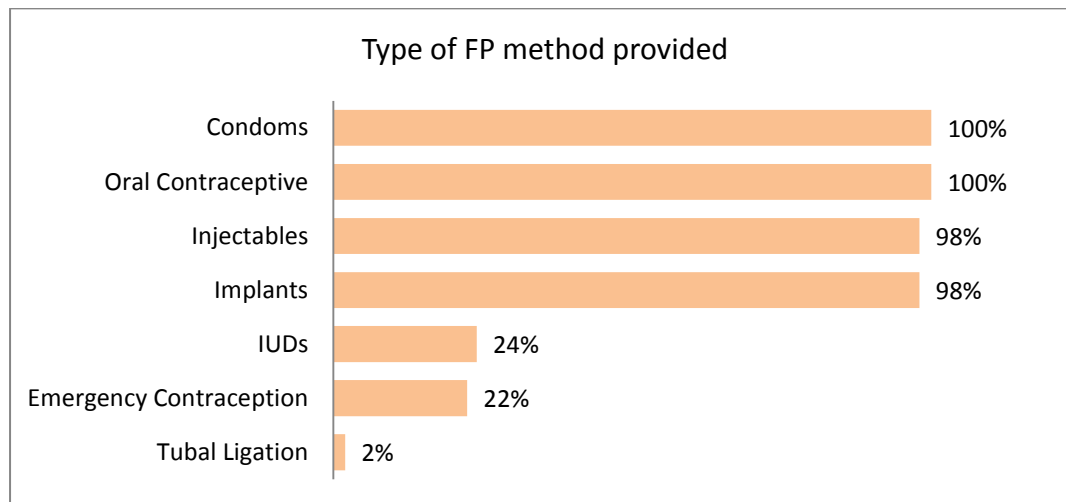
A total of 40 supervisors were interviewed (11 from Southern, 11 from Central, and 18 from Eastern Province). Twenty-seven per cent were males and 73 per cent females. Half (50%) of the supervisors were enrolled midwives, followed by registered nurses (18%) and registered midwives (15%). The supervisors' experience in supervising FP ranged from five months to 33 years.

3.2 Provision of FP Services

All 42 facilities provided FP services, with an average of three members of staff providing FP services at each of the health centres. The type of FP services provided differed from facility to facility (**Figure 1**). At least 98% of the facilities provided condoms, oral contraceptives, injectables, and implants. Despite an average of three healthcare workers providing FP services at the facilities, less than a third of facilities provided intrauterine devices (IUDs),

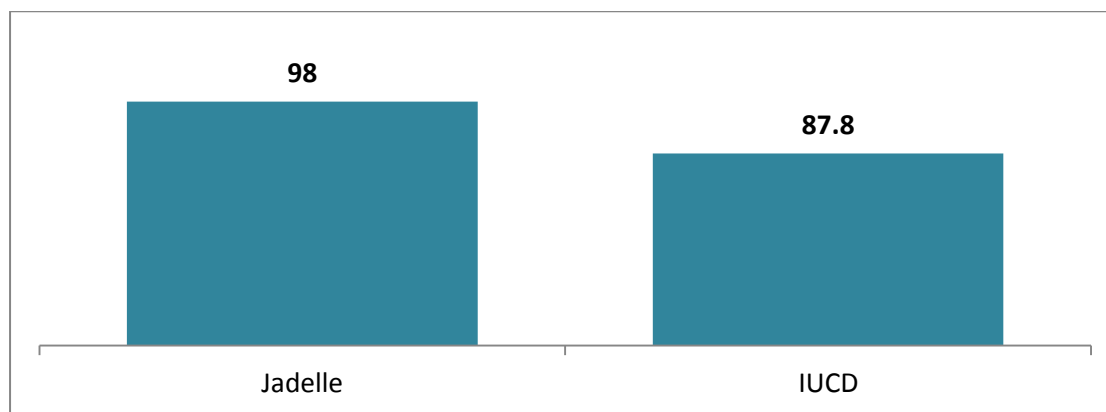
emergency contraceptives and tubal ligation⁵. However, all 42 centres did offer LAFP services. The majority (98%) of the centres provided Jadelle while only 24% offered IUCDs.

Figure 1: Percentage of facilities offering modern FP methods



The health care providers (n=49) were asked the type of LAFP methods they were aware of; eight in ten respondents indicated that they were aware of both IUCD and Jadelle (**Figure 2**).

Figure 2: Awareness level about two LAFP methods



3.3 Knowledge & skills on LAFP

To ascertain the knowledge levels on LAFP, healthcare providers were asked the open-ended question, “*What is your understanding of long acting family planning?*” A small percentage (4%) of the healthcare workers had complete understanding of the LAFP. However, all respondents described LAFP as a form of contraception, such as “a method that prevents

⁵ Note: Tubal ligation can only be done by a medical doctor, which puts it in a higher-level LAFP category in the sense that it requires a specific human resource cadre for service provision rather than a specific skills training of existing cadres of staff.

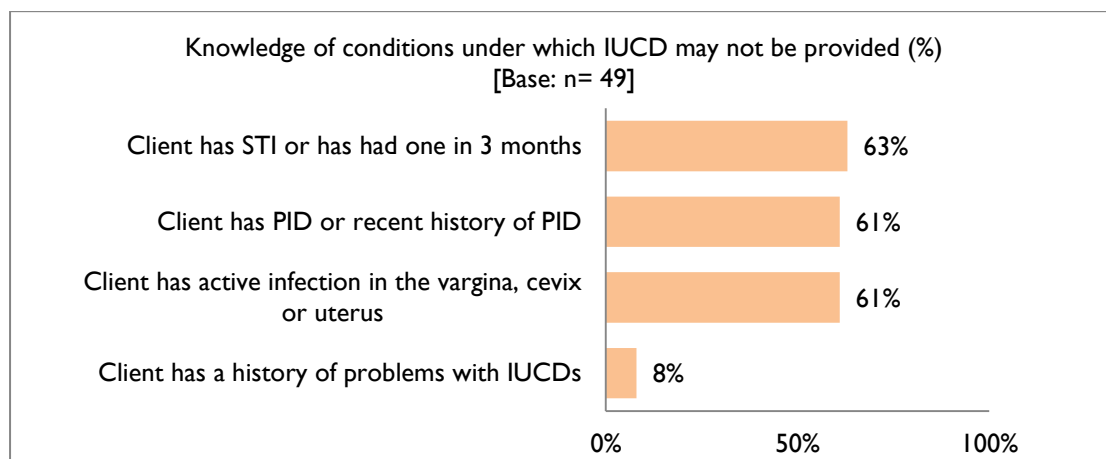
pregnancies”, “spacing of children” or “gives time for a woman to rest from child-bearing for a long time.”

From a list of options of how LAFP services were chosen by clients, 87.9% of respondents indicated that the majority of clients obtained LAFP services voluntarily, but 63.3% also indicated that LAFP services were provider-initiated (i.e. through provision of client-specific counselling and education on LAFP during the clinic visit). Only 10% of the respondents indicated that some of the clients were coerced. Adolescent provision of LAFP was cited by only 30% of respondents, and, of those, they reported that adolescents did not prefer LAFP methods or that none had requested such a service.

3.3.1 Knowledge on IUCD

To further ascertain the retention of knowledge of the healthcare workers, the respondents were asked under what medical conditions an IUCD should not be inserted. The knowledge levels were found to be average. Two-thirds of the respondents correctly indicated that an IUCD should not be inserted when the client has a sexually transmitted infection (STI) or has had one in the past three months, client has pelvic inflammatory disease (PID) or recent history of PID, or the client has active infection in the vagina, cervix or uterus. However, less than 10% of the respondents recalled that an IUCD should not be inserted in a client with a history of problems with IUCDs (**Figure 3**).

Figure 3: Knowledge of conditions under which IUCD may not be provided



The respondents were able to correctly recall the side effects of IUCDs, which include heavy bleeding (75%), abdominal cramps (61%), spotting (44%), and PID (30%). Urinary tract infection was erroneously cited by 36.7% of the clients.

3.3.2 Skills on IUCD

The respondents were asked if they had inserted any IUCD after the training. Only 15 trained healthcare providers (30%) had ever inserted an IUCD. Of these 15 respondents, 47% claimed to have inserted an IUCD only once, while 53% claimed to have applied the skill at least two times (**Table 2**). None had inserted an IUCD in an adolescent, and only 6% indicated they had inserted one in postpartum clients.

Table 2: Number of IUCD inserted

Number IUCD inserted by percentage [Base: n=15]		
Number of IUCD inserted	n	%
1	7	47%
2	2	13%
3	4	27%
4+	2	13%

In trying to further measure the healthcare providers’ skills in inserting the IUCD, the 15 respondents were asked if they had ever experienced any challenge when inserting an IUCD. Only 16% indicated that they had experienced some challenges. When the respondents were asked what challenges they faced when inserting the IUCD, client discomfort and lack of equipment and supplies were the commonly mentioned challenges. Male providers indicated that their clients were not comfortable with accessing LAFP services from a male provider.

Generally, the majority of the 49 respondents (73%) rated themselves as either “very competent” or “competent” in inserting IUCDs, while 23% were not sure of their competency levels. However, when this data is stratified by health workers who have inserted an IUCD since the training (n=15) and health workers who have not inserted an IUCD since the training (n=34), it is apparent that perceived competence decreases in those without practical experience (**Figures 4 and 5**). Those health workers who have inserted an IUCD since training were largely confident in their skills (93% as competent or very competent), with only one person (7%) not sure of their competency and none who felt that they were incompetent. On the other hand, only twenty-two health workers (65%) who have *not* inserted an IUCD since their training felt competent or very competent in their skills, and 12 people (35%) felt either unsure or incompetent.

Figure 4: Competence levels in persons who have inserted IUCDs

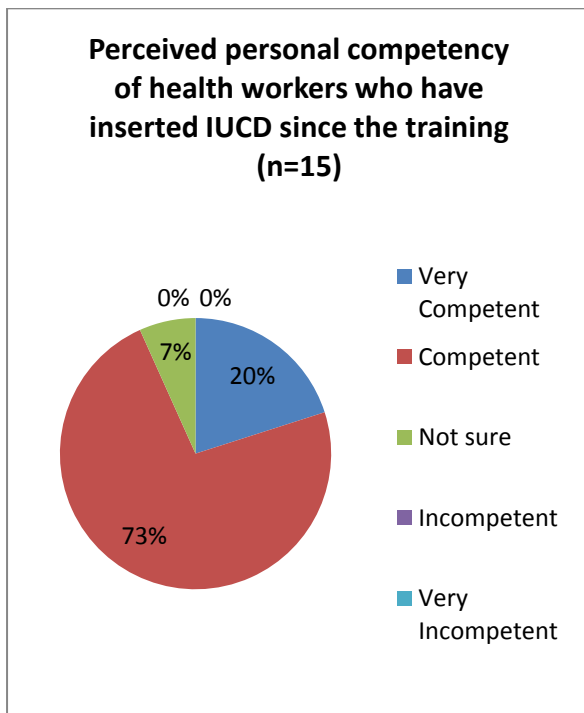
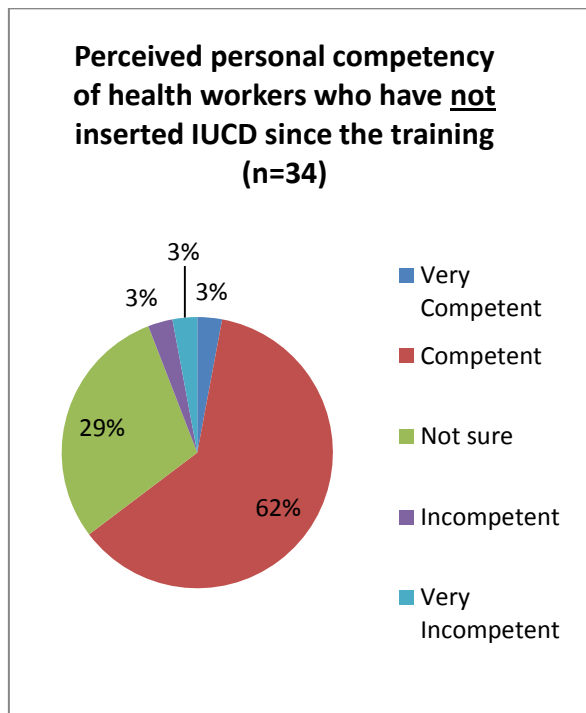


Figure 5: Competence levels in persons who have not inserted IUCDs



Forty-one per cent of the health care workers (n=20) claimed to have removed an IUCD before, with experience ranging from one to 20 removals, with the majority having removed between one and five (**Table 3**). One healthcare worker reported removing over 10 IUCDs.

Table 3: Number of IUCD removed

Number IUCD removed by percentage [n=20]		
Number of IUCD removed	n	%
1 to 5	15	75%
6 to 10	4	20%
Over 10	1	5%

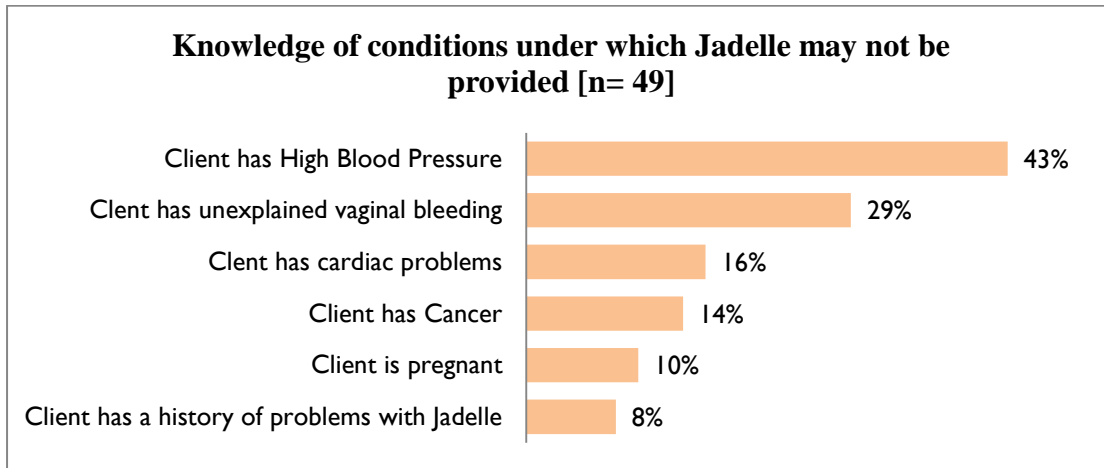
Some respondents indicated that there were some challenges in removing IUCDs, which included missing strings and lack of equipment. When asked about their perceived competency levels in removing IUCDs, 39 health workers (80%) felt competent or very competent, while ten health workers were unsure or felt they were incompetent in this skill.

3.3.3 Knowledge on Jadelle

To further ascertain the retention of knowledge of the healthcare workers, the respondents were asked under what conditions Jadelle should not be inserted. The knowledge levels were found to be average. In responding to conditions in which Jadelle should not be provided,

some respondents correctly cited the following: unexplained vaginal bleeding, hypertension, prolonged bleeding, cervical cancer, suspected or known pregnancy, headaches, diabetes, and heart conditions (**Figure 6**).

Figure 6: Knowledge of conditions under which Jadelle may not be provided



The commonly-cited side effects of Jadelle were heavy bleeding and weight gain. Headaches, abdominal cramps and nausea were also cited as some of the side effects. The respondents identified precautions they usually take when inserting Jadelle, such as sterilizing equipment, use of surgical gloves and other aseptic techniques, including infection prevention. No incorrect answers were given by respondents.

3.3.4 Skills on Jadelle

Respondents were asked if they have inserted any Jadelle since the training. Ninety six per cent of the respondents reported experience with inserting Jadelle. Of these, at least a third (34%) reported to have inserted over 31 Jadelle, followed by 26% who reporting to have inserted between 11- 20 (**Table 4**).

Table 4: Number of Jadelle inserted

Distribution of respondents by number of Jadelle insertions [n=47]		
Number of Jadelle inserted	n	%
1 to 10	10	21%
11 to 20	12	26%
21 to 30	9	19%
31 +	16	34%

The respondents rated themselves as either very competent (36%) or competent (64%) with regard to inserting Jadelle. When asked if they have ever experienced any challenge when inserting Jadelle, about half (51%) of the respondents indicated that they had experienced a challenge. Commonly-mentioned challenges included lack of supplies and equipment (e.g.,

antiseptic supplies, sterilizing equipment), managing excessive bleeding, inserting the rods, and lack of privacy.

Ninety-six per cent of the respondents had experience with removing Jadelle. At least two-thirds (67%) of the respondents claimed to have removed 1-10 Jadelle, while 19% claimed to have removed 11-20 Jadelle. Less than one-fifth (14%) claimed to have removed 21 or more Jadelle (**Table 5**).

Table 5: Number of Jadelle removed

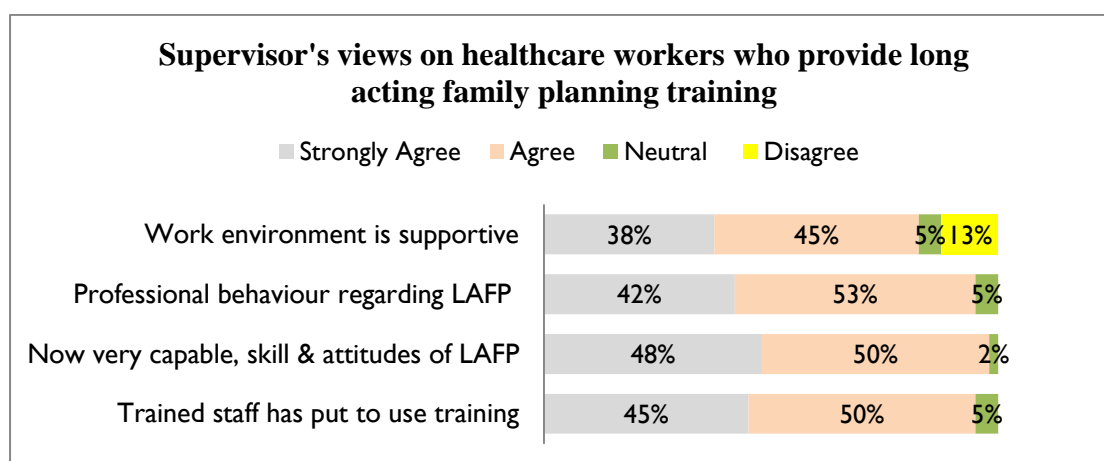
Distribution of respondents by numbers of Jadelle removed [n=43]		
	n	%
1 to 10	29	67%
11 to 20	8	19%
21 to 30	2	5%
41 to 50	1	2%
Over 50	3	7%

When asked what challenges were possible when removing Jadelle, healthcare providers mentioned cases where rods had been inserted too deeply and were difficult to locate or rods that went missing. Another challenge is when the healthcare provider wants to remove Jadelle but cannot because of inadequate supplies and equipment. The majority (69%) had personally experienced these types of challenges.

3.4 Supervisors' views on staff providing LAFP

To triangulate the self-report by providers on their personal levels of competence in providing LAFP, their respective supervisors were asked their perspective of LAFP services at their centres. Of the 40 supervisors, 95% either “strongly agreed” or “agreed” that the trained staff have put the training into use and that they have exhibited professional behaviour towards LAFP. Ninety-eight per cent “strongly agreed” or “agreed” that the trained staff has the necessary capability, skills and attitude on LAFP, and 83% indicated that the work environment for the healthcare workers providing LAFP was supportive (**Figure 7**).

Figure 7: Supervisors' Views on how Trained Staff Apply LAFP Training



However, the supervisors highlighted some weaknesses in provision of LAFP, including inadequate supplies (e.g., lignocaine) and some specific equipment (sterilizers); inadequate number of staff; and stock-outs, especially of IUCDs. Infrastructure constraints to FP service delivery were also mentioned, including lack of privacy and lack of a FP room. Nonetheless, the supervisors overwhelmingly felt that LAFP services had greatly improved in efficiency and effectiveness upon the return of staff from the training.

3.5 Attitudes and Perceptions of LAFP

The assessment collected qualitative information to measure the attitude towards LAFP services. The majority of the healthcare workers had a positive attitude towards LAFP (Table 6).

Table 6: Attitude of healthcare workers towards LAFP

Attitude of healthcare workers towards LAFP		
	%	Verbatim
Positive	92%	<p><i>“Helps mothers to rest from conceiving for a long time; it is good and should be encouraged. Generally, child spacing is seen as a means of enhancing good health and well-being of the mother and the child.”</i></p> <p><i>“It provides an opportunity for the mother; good for child spacing; it also gives space to plan for other things.”</i></p> <p><i>“Good method for women to stay off child-bearing for a long time. It improves on women’s quality of life; it lessens FP visits to the facility; they prevent conception so they are good, gives women time to rest.”</i></p>
Negative	8%	<p><i>“Some cultural beliefs don’t support family planning method; this is the reason why some men are reluctant to accept and support use of contraceptives by their spouses.”</i></p>

Twelve per cent of the respondents “strongly agreed” or “agreed” with the statement that they preferred providing short-term FP methods to LAFP, indicating a strong provider preference for LAFP methods. Furthermore, 58% did not feel that LAFP services were involving and time-consuming (Table 7).

Table 7: Healthcare providers’ reactions toward providing LAFP services

	It is very involving and time consuming to provide LAFP methods [n=49]	I prefer providing short term FP methods to LAFP [n=49]
<i>Response</i>	%	%
Strongly Agree	6%	2%
Agree	33%	10%
Not sure	2%	10%
Disagree	31%	47%
Strongly Disagree	27%	31%

Providers stated that the common myths coming from the community include that implants can enter into the bloodstream and go to the heart (65%), one cannot do hard work (49%), cause infertility (35%), or cause cancer (20%), or that Jadelle rods can break inside the body (10%) or lead to severe loss of weight (8%) (Table 8).

Table 8: Common myths towards LAFP

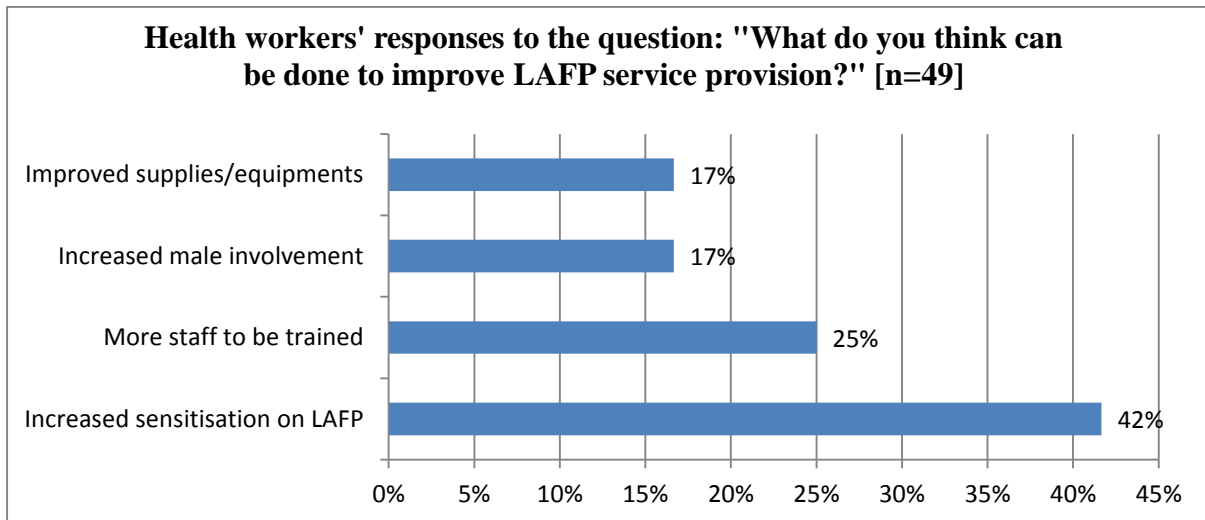
Common myths surrounding LAFP [n=49]		
Type of common myths	n	%
The implant gets into the blood stream and goes to the heart	32	65%
One cannot do hard work	24	49%
Causes infertility	17	35%
Causes cancer	10	20%
The rod breaks inside the body	5	10%
Leads to severe loss of weight	4	8%

In responding to whether their clients preferred LAFP, at least two-thirds (61%) agreed, stating reasons such as: it lessened FP visits, clients forgot about FP for a long time, and they avoided unwanted pregnancies. Thirty eight per cent did not think clients preferred LAFP, stating reasons such as doubt on the duration they wanted to suspend childbearing or fear of permanently losing their fertility. The most common reason for discontinuing LAFP was intent to conceive; another reason stated for discontinuing (although uncommonly) was heavy bleeding.

The uptake and preference of LAFP has generally been low, despite its main benefits. In light of this fact, the respondents were asked their views on how to improve the uptake of LAFP.

The responses offered included: increasing sensitization on LAFP (41%), training more staff, ensuring availability of essential equipment, and increasing male involvement (**Figure 8**).

Figure 8: Proposed measures to improve LAFP services



3.6 Utilization of LAFP Services

Measuring utilization of LAFP was done at two levels. First, the questionnaire asked both groups of respondents (health care providers and supervisors) if they have noticed any change in the number of clients utilizing LAFP services after the training, reasons for the observed change, and the number of clients they see in a week. Second, the assessment team checked the facility registers to collect data on the uptake of LAFP.

Almost all health care providers (45 of 49) agreed that LAFP services had increased at their centre on account of services availability, trained staff, increased sensitization of clients by service providers, and increased awareness about the benefits of LAFP services.

Among the 42 health facilities visited, an average of 62 clients sought any type of FP services per facility within a month. Through a review of available FP records from the past one year, the facilities identified 3037 FP visits of which only 5% (162) were for LAFP services. An average of three clients per month received LAFP services, which were provided by the trained LAFP provider. Only one client, or none at all, sought IUCDs per month, compared to three who go for Jadelle implants per month (**Table 9**).

Table 9: Number and Types of LAFP services provided in an average month by 49 LAFP-trained health providers at 42 health facilities

	LAFP clients seen in an average month	FP clients coming for IUCD in a month	FP clients coming for Jadelle in a month
Total (<i>all health facilities</i>)	162	5	157
Mean (<i>per provider</i>)	3.00	0.10	3.27

3.7 Availability of LAFP equipment, supplies and required infrastructure

Provision of LAFP services requires that a health facility has specific equipment, supplies, and infrastructure. Most of these requirements were available, and most respondents felt that, beyond having trained staff available, their facilities were equipped to offer LAFP.

While 100% of health facilities had Jadelle, and 98% had combined injections available, only 29% had IUCDs available. Less than 20% of health facilities had other LAFP services available (i.e. tubal ligation, vasectomy and cervical rings) (**Table 10**).

Table 10: Availability of LAFP commodities and LAFP services

Availability of LAFP commodities / services	% availability
Cervical rings	5%
Tubal Ligation services	7%
Vasectomy services	17%
IUCD	29%
Combined Injection	98%
Jadelle	100%

To provide LAFP services, health facilities require specific equipment including a blood pressure (BP) machine, stethoscope, examination couch, refuse bin, and scale. At almost all the facilities, clinical equipment was readily available, with 80% of health facilities having most of the available equipment (**Figure 9**). The one piece of equipment that was not available in more than half the facilities were models for explaining the procedure.

The health centre infrastructure also requires a private area to provide the LAFP services. Seventy-eight per cent of health centres reported availability of a private area.

Figure 9: Availability of equipment / infrastructure for LAFP

Availability of equipment / infrastructure for LAFP	%
Uterine sound	39%
Models for explaining procedure	39%
Privacy	78%
Tape for height	81%
Examination couch	85%
Kidney Dish	88%
Insertion and removal equipment for Jadelle	90%
Stethoscope	93%
Scale	95%
Thermometer	98%
BP Machine	100%

The instruments for insertion and removal of Jadelle were available in most (90%) of the health facilities. However, in terms of IUCD instruments for removal and insertion, about 70% had various instruments, but of note was the low percentage (39%) that had the uterine sound.

Critical supplies and equipment needed for provision of hygienic and sterile services include gloves, means of waste disposal, and various types of sterilisation equipment. Notably, an autoclave was available in only 49% of facilities. Other supplies were available in most centres, with 83% having sterile gloves and 98% having a sharps box (**Table 11**). In terms of infrastructure, the health centre requires a water supply. Twenty-four per cent of health facilities did not have a water supply.

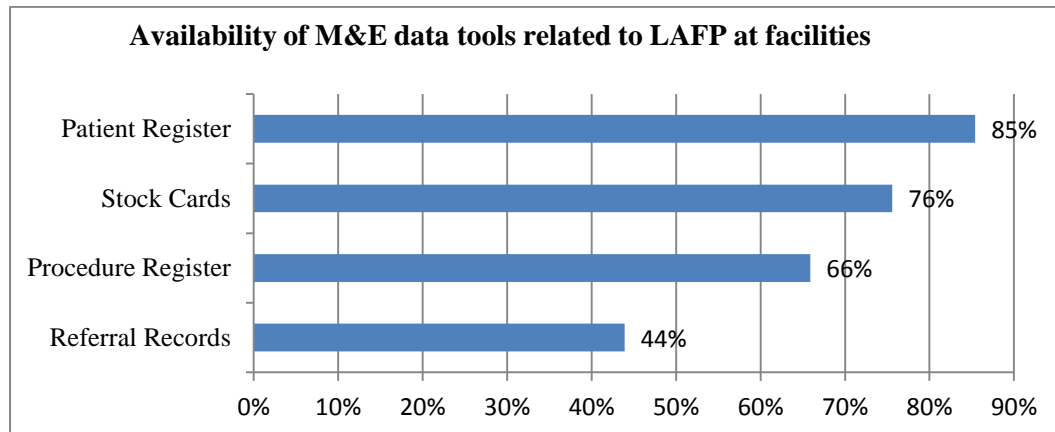
Table 11: Availability of sterilisation equipment / supplies

Equipment / supplies	%
Pressure Cooker	39%
Autoclave	49%
Heavy Duty Gloves	61%
Water Supply	76%
Clinical Sterile Gloves	83%
Refuse Bin	88%
Sharp Box	98%

The LAFP guidelines require specific registers, forms and cards for documentation and monitoring of LAFP service provision. Record keeping was found to be problematic, both in terms of availability of the specific tools and in terms of completion of information in the tools. Fifteen per cent did not have a patient register, 24% did not have stock cards, 34% did

not have a procedure register, and 56% did not have referral records (**Figure 10**). In addition, 40% of health facilities did not have complications records available.

Figure 10: Availability of record-keeping tools related to LAFP

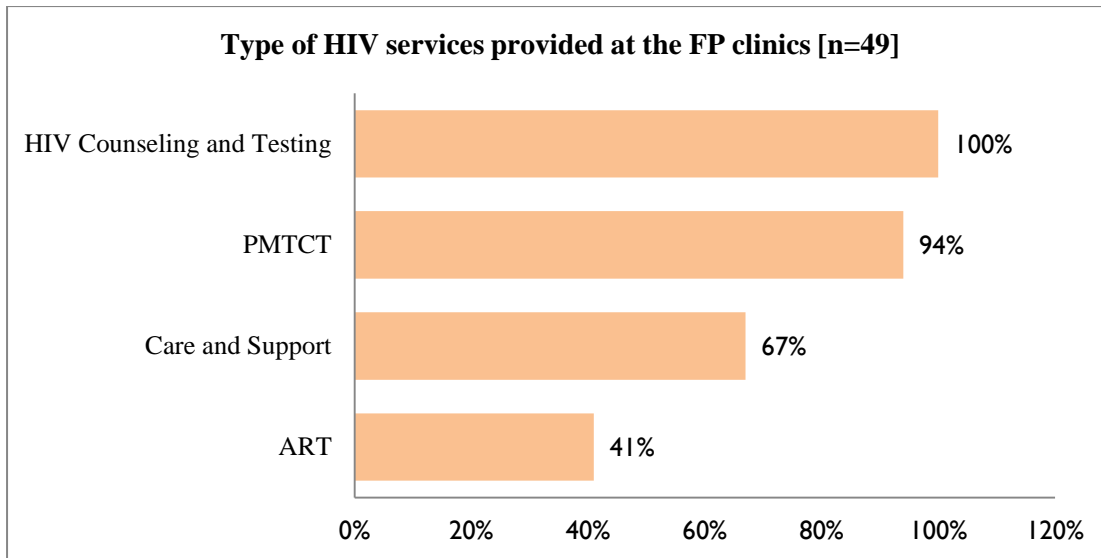


3.8 Integration of HIV and AIDS services and male involvement into LAFP provision

In trying to measure integration of HIV and AIDS services into LAFP provision and male involvement in promoting FP services at the facility, the healthcare providers were asked a series of questions which included: type of HIV services offered at the facilities; if the providers encouraged clients to come with their male spouse for FP; if clients come with their male spouse for FP; and the frequency of clients coming with their male spouse for FP.

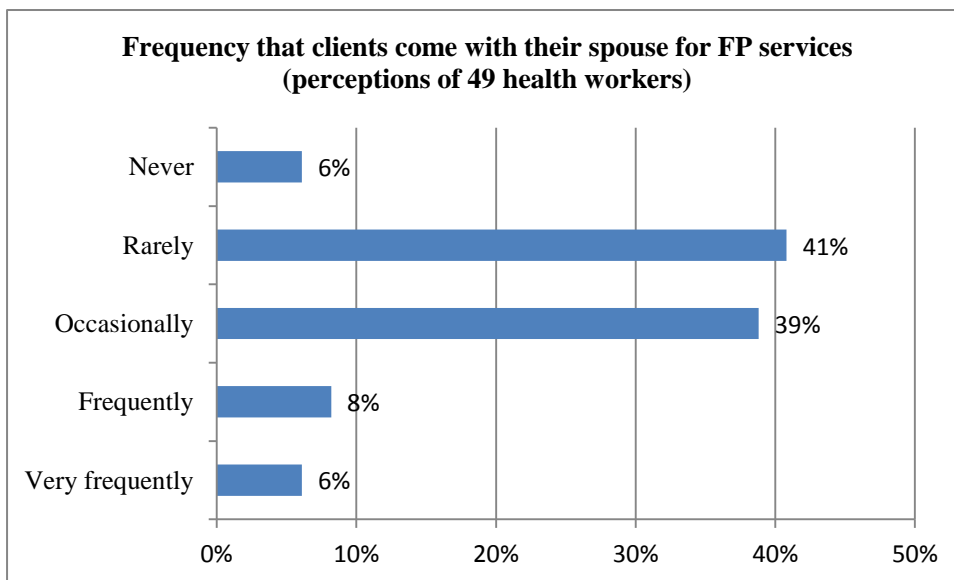
All the respondents indicated that their respective facilities were providing HIV services, specifically: HIV counselling and testing, prevention of mother-to-child transmission (PMTCT), care and support, and anti-retroviral therapy (ART). These services have been integrated in the provision of FP services, in the sense that a client can receive HIV services during the same visit to the health centre for LAFP services, although not necessarily in the same room as where FP services are provided (**Figure 11**).

Figure 11: Type of HIV and AIDS services provided at the FP clinic



While male involvement was encouraged by 91% of the respondents, only 70% of the health care workers indicated that some clients visit the facilities with their male partners. However, when asked the frequency that clients visit the facilities with their male spouse for FP services, respondents stated that attendance of males was occasional and rare (**Figure 12**).

Figure 12: Frequency of clients visiting with their male partners for FP services



CHAPTER 4: DISCUSSION, CONCLUSIONS & RECOMMENDATIONS

4.1 Discussion

Healthcare providers play a pivotal role in the availability and use of LAFP. Providers not only conduct LAFP counselling, insertion and removal, but also are “gatekeepers” whose attitudes and actions influence whether and how clients use LAFP. This study revealed that the majority of LAFP service providers are nurses (both registered and enrolled), and their attitudes to LAFP were found to be positive. Once a trained LAFP provider was available at a health centre, there was an observed increase in utilization of LAFP services. Respondent’s knowledge of LAFP services (IUCD and Jadelle) was high, although not 100% as expected, which could be attributed to recall bias as well as forgetfulness, which could be attributed to the lack of opportunity to provide IUCDs in the time since the training. Where supplies, equipment and infrastructure were available, the application of the skills they learned was high (96% for Jadelle, but only 30% for IUCD).

Objective 1: Application of knowledge and skills acquired from LAFP training

The respondents demonstrated a high level of retained knowledge concerning the nature of IUCDs and Jadelle implants, including the mechanism of action in preventing pregnancy, side effects and contraindications. However, the assessment noted gaps in ability of healthcare workers to recall complete information about conditions in which LAFP should not be provided.

Experience with inserting and removal of Jadelle was notably high. However, the application of skills of IUCDs was not demonstrated. Only about 30% of respondents had inserted or removed an IUCD, and the average incidence was once. A plausible explanation was the non-availability of uterine sounds (61% of the centres did not have), autoclaving equipment (not available at 51% of centres) and the unavailability of IUCDs (71% did not have).

Despite not having done the procedures since the training, most respondents rated themselves as competent at inserting and removing IUCDs. This high confidence could be attributed to the ability of the training to build knowledge and skills. However, for those who had not done the procedure since training, their confidence in their skills was lower than those who had done the procedure.

Objective 2: Providers’ attitudes toward and perceptions of the LAFP Services

Positive attitudes and perceptions of LAFP methods have been recognized as an important factor in utilization of LAFP services by clients. The rapid assessment revealed that the respondents’ views about LAFP were mostly positive, a critical factor for countering negative beliefs and myths demonstrated by clients.

The respondents recognized community perceptions about LAFP. Some respondents indicated that some clients did not favour LAFP methods because of their indecision about the duration they wanted to suspend childbearing or fear of permanent loss of fertility. Respondents stated common myths held by the community about LAFP, such as that Jadelle implants could migrate to the recipient's heart, but healthcare providers countered such misconceptions through counselling. Training of healthcare providers should continue to extensively address attitudes and perceptions about LAFP, with guidance on how healthcare providers can address community misperceptions.

Objective 3: Adherence to LAFP guidelines

The rapid assessment showed that knowledge of the LAFP guidelines was high among the respondents, as measured by levels of knowledge and skills. Willingness to adhere to LAFP guidelines was reported by both the healthcare providers and their supervisors. A barrier to adhering to the LAFP guidelines was mostly lack of supplies, equipment, and infrastructure requirements. As was reported, limiting factors included lack of sterilizing equipment and specific equipment for IUCD and Jadelle insertion and removal (e.g., uterine sounds, which are necessary for a complete pelvic examination and insertion of IUCDs). Clinics that lacked critical equipment such as uterine sounds were therefore not able to provide services.

Objective 4: LAFP service utilization

An increase in LAFP service utilization was reported by both healthcare providers and their supervisors. The inspection of records also corroborated the claims of increased utilization by examining trends over the past year⁶. This positive change was attributed to increased availability, increased sensitization and increased client awareness about the benefits of LAFP services. However, the assessment checklist noted that many centres did not have adequate or complete documentation of their services because their records did not conform to the reporting requirements of the Ministry.

Objective 5: HIV services and male involvement integration into FP services

The majority of respondents (98%) reported encouraging male involvement in FP to their clients, but conceded that actual attendance of males at FP services was occasional and mostly rare. Lack of privacy and appropriate space to provide couple's counselling could be a reason for the low male involvement. However, sociocultural issues may still need to be considered for the low male turn-out.

HIV services (counselling and testing and PMTCT) were reported to have been incorporated in FP services at 98% of the facilities. The assessment did not capture additional information on exactly how integration occurred and which models were most effective. There are many calls for integration of services in general in Zambia beyond FP and HIV service integration.

⁶ Due to incomplete record-keeping at clinics, the trend data was not included in this report.

Studies are yet to inform which model would work best for Zambia given the various vertical programmes in the Zambia health settings which are recommended for integration.

4.2 The LAFP Assessment in Zambia: Examining the findings in the wider international context

The assessment methodology included a literature review to compare Zambia's findings to findings from other publications that documented the effectiveness of FP training programmes. An evaluation by FHI360 assessed the quality of FP training to support future training improvements using two main approaches: checklists to record training observations, and evaluation of trainees during service provision (when providing counselling and performing implant and IUCD insertions and removals on models and on clients)⁷. Manisoff et al. assessed the effect of the training by a questionnaire, administered after the students had been back at their places of work, as a basis for evaluating the effect of the training⁸. The study also conducted on-site interviews with trainees and their medical and nursing supervisors.

In contrast to the above studies, this Zambia assessment was not an evaluation of the ZISSP/MOH trainings in the "strict" sense of evaluation studies, but rather assessed the extent of application of knowledge and skills learned from the trainings by the participants. However, the findings are comparable in that the respondents had *learned* skills in LAFP and were now applying them. Similar to Zambia, health providers reported positively on the skills that they obtained through LAFP training. The report from Senegal⁹ quoted a participant who said, "Before my training, I never thought that one day I would insert implants or intrauterine devices."

All the studies were premised on the understanding that training could be an effective way of addressing unmet need for family planning. A study in India¹⁰ measured two aspects of the training programme: the extent to which nurses achieved the level of (1) factual knowledge, clinical skill and judgment, and 2) competence, as outlined in the primary objectives of the programme. Similar to the Zambia assessment methodology, the study used a questionnaire, log of activities, and interviews. The Zambia assessment showed that the majority of nurses who participated in the LAFP training achieved satisfactory factual knowledge, clinical skill and judgment, and competence.

⁷ Fhi360 (2012). Comprehensive Family Planning Training Evaluation Report. <www.fhi360.org/sites/default/files/media/document>

⁸ Manisoff, M., Davis, L.W., Kaminitzy, H.A., and Payne, P (1976). *The family planning nurse practitioner: concepts and results of training*. AM J Public Health; 66(1): 62-64.

⁹ USAID/Senegal (2012). *Nurses Train to Provide Long acting family Planning Methods*. <Senegal.usaid.gov/en/node.490>

¹⁰ Weisbuch, J. B and Watson, C (1970). *Evaluating the training of nurses to do family planning work in India*. Public Health Reports; 85(8): 707-715.

A case study by Quereshi et al. concluded that their findings suggested that training may be associated with increased service use through improvement in quality of services¹¹. The Zambia assessment could corroborate this conclusion; respondents reported increases in utilization of LAFP at their health centres following their training. A study in Egypt also found an association between improved FP training for nurses and positive changes in FP knowledge, attitudes and behaviour among women attending government clinics¹². The Egypt study also noted that female clients especially displayed increased knowledge about contraceptives. While the Zambia assessment did not include interviews with clients, supervisors reported a positive impact of the LAFP providers once they had returned from the LAFP training.

4.3 Conclusion

The rapid assessment provides valuable insight into the degree of retention and application of knowledge, skills and attitudes in LAFP services for trained health workers. The respondents demonstrated a high level of knowledge concerning the nature of IUCDs and Jadelle, their mechanisms of action in preventing pregnancy, side effects and contraindications. The respondents' personal views about LAFP were mostly positive, and they not only could identify specific myths about LAFP held by the community but also reported that they offered sensitization and counselling to debunk the myths.

Almost all of the respondents (98%) agreed that LAFP service provision had increased at their centre on account of the service being available, increased sensitization, and increased client awareness about the benefits of LAFP services. On average, the respondents saw 100 FP clients per week, of whom seven to eight were LAFP clients. However, while 93% of the respondents had inserted Jadelle since the training (most commonly 20 insertions per provider), only 15 (30%) of respondents had inserted an IUCD after the training, of which about half had only inserted an IUCD once.

In terms of health centre capacity to provide LAFP services, the assessment found that the majority of the FP services were operated by nurses and nurse midwives, and few staff had opportunity to be trained in LAFP. All the centres at which the respondents were based were offering LAFP, although mostly Jadelle implants (98%) compared to IUCDs (30.6%). The instruments for inserting and removal IUCD were available in about 70% of the health facilities, but a low percentage (39%) had the uterine sound. The instruments for insertion and removal of Jadelle were available in most (90%) of the health facilities. While there was generally good availability of infection control supplies (e.g., gloves, methylated spirits, etc.), many health facilities did not have necessary sterilization equipment (e.g. autoclaves or

¹¹ Quereshi, A. M. (2010). *Case Study: Does training of private networks of family planning clinicians in urban Pakistan affect service utilization*. BMC International Health and Human Rights; 10: 26 <<http://www.biomedcentral.com/1472-698x/10/26>>

¹² Halawa, M., Bashay, M.F., Eggleston, E., Hardee, K., Kafafi, L., and Brown, J.W (1995). *Assessing the impact of family planning nurse training program in Egypt*. Population Research and Policy Review 14: 395-409.

pressure cookers). In addition, most centres (61%) did not have models for demonstrating LAFP methods. Record keeping was identified as problematic.

Training of healthcare providers in LAFP has demonstrated an increase in utilization of LAFP at those facilities within a relatively short period of time. While not measured by this rapid assessment, the uptake of LAFP services in turn could positively contribute to improvements in the CPR in the surrounding health facility catchment area and lower the unmet need for FP by the community. If training in LAFP services could be done on a larger scale, the intervention has the potential to contribute to increasing national CPR and lowering unmet need. However, training alone cannot result in improved uptake of services without wider support to health facilities to provide quality services, such as in the area of supply chains systems and infrastructure (equipment and confidential space).

4.4 Recommendations

Based on this rapid assessment, the following recommendations are prepared for the MCDMCH, ZISSP, and other implementing partners supporting LAFP training and service provision.

Action	Intervention Rationale	Key Evidence Available
<p>1. Scale up LAFP training, including opportunities for post-training mentorship to reinforce knowledge and skills (such as through Clinical Care Teams or other existing structures).</p>	<p>For LAFP training to effectively contribute to meeting national reproductive health targets (i.e. modern CPR, unmet need), the training needs to be implemented at a large enough scale to have an impact.</p> <p>Post-training mentorship can reinforce key knowledge and skills for quality service provision.</p>	<ul style="list-style-type: none"> • While many health facilities have an average of three or more nurses providing FP counselling and services, often one (or even none) of these staff have been trained to provide LAFP. • Knowledge levels on some aspects of LAFP services, such as client eligibility screening, require refresher trainings and/or in-service mentorship following the initial training. Over one-third of health providers could not recall one or more specific conditions under which Jadelle or IUCDs may not be provided to a client. Also, 27% of trained providers were not sure or felt incompetent to insert IUCDs.
<p>2. Examine root causes of IUCD stock-outs at health facilities, and remove barriers within logistics systems to enable continuous availability of IUCD supplies.</p>	<p>Provision of IUCD as LAFP is lagging because of non-availability of IUCDs.</p>	<ul style="list-style-type: none"> • Lack of IUCD supplies prevent application of skills by trained health care workers. Only 15 (30%) had inserted an IUCD at least one time since their LAFP training. • Only 29% of health centres had IUCDs available at the time of the assessment.
<p>3. Assess status of required equipment at health facilities, and rectify as needed, including models for LAFP counselling, uterine sounds, and infection control equipment (autoclaves and pressure cookers).</p>	<p>Lack of equipment is a barrier to providing LAFP services in line with the guidelines.</p> <p>Models for demonstrations are required for effective LAFP counselling.</p>	<ul style="list-style-type: none"> • The assessment observed low availability of autoclaves (49%), pressure cookers (39%), models (39%) and uterine sounds (39%) at health centres offering LAFP services.

<p>4. Increase opportunities for healthcare providers to receive specific training and in-service mentorship on the importance of record keeping.</p>	<p>Incomplete data hinders processes of evaluation and documentation of the evidence on LAFP.</p>	<ul style="list-style-type: none"> • Fifteen per cent of centres did not have a patient register, 24% did not have stock cards, 34% did not have a procedure register, and 56% did not have referral records. • Where record-keeping tools were available, not all information was complete in the existing tools.
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APPENDICES

Appendix I: LAFP Training Agenda

Session Length	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6 & Day 7	Days 8, 9, 10 & 11	Day 12
30 minutes	Opening session	Recap	Recap	Recap	Recap	Recap	Recap	Recap
1 hour, 30 minutes	Jadelle pre-course questionnaire	Indications and precautions for Jadelle; Client assessment; Management of Jadelle side effects	Pre-course Overview of IUD	Pelvic examination; Demonstration	Management and organizing IUD and Jadelle service	Check out for IUD/Jadelle counselling/insertion and removal	Practicum	Practicum
1 hour, 30 minutes	Family Planning Overview; Introduction to Jadelle	Infection prevention	Activity loading IUD	IUD insertion technique	Mid-course evaluation; Check out for IUD and Jadelle	Check out for IUD/Jadelle counselling/insertion and removal	Practicum	Practicum
1 hour, 45 minutes	Counselling; Activity: Counselling session; Demonstration by facilitator	Jadelle insertion technique; Post insertion follow up care	Indication and precautions for IUD; Medical eligibility criteria; Managing IUD side effects	Follow – up care; IUD removal technique	Check out for IUD and Jadelle	Check out for IUD/Jadelle counselling/insertion and removal	Practicum	Presentations on the action plans
1 hour	Return counselling demonstration	Jadelle removal technique; Mid-course evaluation	Method specific counselling for IUD	IUD Follow up care	Check out for IUD and Jadelle	Check out for IUD/Jadelle counselling/insertion and removal	Practicum	Closing ceremony/ End of Course

Appendix II: Research Instruments

The following research instruments are attached:

1. Health Care Provider Questionnaire (page 30)
2. Health Care Provider Supervisors Only Questionnaire (page 42)
3. Long Acting Family Planning Facility Checklist (page 46)

ZAMBIA INTEGRATED SYSTEMS STRENGTHENING PROGRAM (ZISSP)

ASSESSMENT OF THE APPLICATION OF LONG ACTING FAMILY PLANNING
TRAININGS OF HEALTHCARE PROVIDERS

Health Care Provider Questionnaire

- All spaces **MUST** be filled in.
- Interviewer Code:

Introduction

Greetings, I am part of a team from the Ministry of Health (MOH), Ministry of Community Development Mother and Child Health (MCDMCH) and Zambia Integrated Systems Strengthening Programme (ZISSP) that is evaluating the training programme conducted on Long Acting Family Planning Methods. The lead consultant of this study is Prof. Sekelani S. Banda. He has been contracted by ZISSP on behalf of the two Ministries. . The results of this evaluation will be used to improve future training on Long Acting Family Planning methods. The report of this interview and other findings will be recorded in such a manner that they cannot be attributed to you and what you say will be kept confidential for your identity purposes. Do you agree to proceed with this interview?

Tick as appropriate: Yes / No

1.0 General Questionnaire Particulars

1.1 Questionnaire ID:

1.2: Province: _____

1.3 District: _____

1.4 Health Facility: _____

1.5 Date of interview: ____/____/____

No.	Question	Response	Code
SECTION A: BACKGROUND INFORMATION			
Q1.1	Gender	Male.....1 Female.....2	
Q1.2	How old are you?		
Q1.3	What is your principal professional qualification?	Registered midwife.....1 Registered nurse.....2 Enrolled midwife.....3 Enrolled nurse.....4 Other.....5	
Q1.4	How long have you worked at this facility?	Years Months	
Q1.5	Do you provide family planning services?	Yes.....1 No.....2 → Q1.7	
Q1.6	How long have you actively provided family planning services? (including FP counselling /patient education and actual method provision?)	Enter Years:	
Q1.7	Have you had any training focused on long acting family planning other than that organised by ZISSP/MOH/MCDMCH?	Yes.....1 No.....2 → Q1.9	
Q1.8	How many trainings have you had? How long ago did you have the last training?	Number..... Years Months	
Q1.9	Does this facility <i>provide</i> any modern methods of family planning?	Yes → Q1.11 No	
Q1.10	If no, why?	..... ..... .....
Q1.11	What modern methods of family planning do you provide at this facility? (Select all that apply)	1. Condoms 2. Emergency contraception 3. Implants 4. Injectables 5. IUCDs	

		6. Oral contraceptive pills 7. Tubal ligation (sterilization) 89. Other (specify).....	
Q1.12	How many staff provide family planning services at this facility? <i>(If more than one please request that you would like to talk to the other providers)</i>	.....
Q1.15	How long have you been providing LAFP method(s) specified above to clients?	Years Months	
SECTION B: Knowledge & Skills of Providers in Long Acting Family Planning			
Knowledge			
Q2.1	What is your understanding of long acting family planning?		
Q2.2	Which long acting family planning methods do you know?	1. IUCD 2. Jadelle 3. Other.....	
Q2.3	Do you provide LAFP methods at this facility?	1. Yes 2. No → 2.5	
Q2.4	Which LAFP methods do you provide at this facility?	1. IUCD 2. Jadelle 3. Other (specify).....	
Q2.5	How do clients access LAFP methods at your facility?	1. Voluntarily 2. Provider initiated 3. Coerced	
Q2.6	Do you provide LAFP methods to adolescents?	1. Yes → Q2.8 2. No	
Q2.7	Why don't you provide LAFP methods to adolescents?		
Q2.8	Have you inserted an IUD before?	1. Yes 2. No → Q2.12	
Q2.9	If yes, How many IUCDs have you Inserted?	.....

Q2.10	(Ask Q2.10 if respondents answered Yes(1) to Q2.6) How many of these clients were adolescents?	.....
Q2.11	How many of these IUCDs insertions were done during postpartum period?	.....
Q2.12	Under what medical condition would you not provide an IUCD? (Select all that apply) 1. Client currently has an STI or has had one within the past 3 months 2. Client currently has an active infection in the vagina, cervix or uterus 3. Client currently has pelvic inflammatory disease (PID) or recent history of PID 4. Client has a history of problems with IUCDs 5. Other (specify).....	
Q2.13	What do you think are the challenges when inserting an IUCD? 1..... 2..... 3..... 4..... 5.....	
Q2.14	Have you experienced any of the challenges you have mentioned above when inserting an IUCD?	1. Yes 2. No → 2.11
Q2.15	What challenges have you experienced? 1..... 2..... 3..... 4..... 5.....	
Q2.16	How would you rate your level of competency in inserting an IUCD based on the following scale;	1. Very competent 2. Competent 3. Not sure 4. Incompetent 5. Very incompetent
Q2.17	Have you removed an IUCD before?	1. Yes 2. No → Q2.18
Q2.18	If yes, How many have you removed?	.....
Q2.19	What are some of the challenges when removing an IUCD?	

	1..... 2..... 3..... 4.....	
Q2.20	Have you experienced any of the challenges you have mentioned above when removing an IUCD?	1. Yes 2. No → 2.17
Q2.21	What challenges have you experienced? 1..... 2..... 3..... 4..... 5.....	
Q2.22	How would you rate your level of competency in removing an IUCD based on the following scale;	1. Very competent 2. Competent 3. Not sure 4. Incompetent 5. Very incompetent
Q2.23	What are the side effects of IUCD?	1 Cramps 2 Heavy menstrual flow 3 Spotting 4 Uterine Infection 5 Pelvic Inflammatory Disease? 99. Other (Specify).....
Q2.24	Have you inserted Jadelle before?	1. Yes 2. No → Q2.26
Q2.25	If yes, How many have you inserted?	.....
Q2.26	(Ask Q2.26 if respondents answered Yes (1) to Q2.6) How many of these clients were adolescents?	.....
Q2.27	How many of these insertions were done during postpartum period?	.....
Q2.28	Under what medical condition would you not provide Jadelle?	1..... 2..... 3..... 4..... 5.....
Q2.29	What are some of the challenges when inserting Jadelle?	1..... 2..... 3..... 4.....

		5.....
Q2.30	Have you experienced any of these challenges when inserting Jadelle?	1. Yes 2. No → 2.25
Q2.31	What challenges have you experienced?	1..... 2..... 3..... 4..... 5.....
Q2.32	How would you rate your level of competency in inserting Jadelle based on the following scale;	1. Very competent 2. Competent 3. Not sure 4. Incompetent 5. Very incompetent
Q2.33	Have you removed Jadelle before?	1. Yes 2. No → Q 2.32
Q2.34	If yes, How many have you removed?	.....
Q2.35	What are some of the challenges when removing Jadelle?	1..... 2..... 3..... 4..... 5.....
Q2.36	Have you experienced any of these challenges when removing Jadelle?	1. Yes 2. No → Q2.32
Q2.37	What challenges have you experienced?	1..... 2..... 3..... 4..... 5.....
Q2.38	How would you rate your level of competency in removing Jadelle based on the following scale;	1. Very competent 2. Competent 3. Not sure 4. Incompetent 5. Very incompetent
Q2.39	What are the side effects of Jadelle?	1..... 2..... 3..... 4..... 5.....
Q2.40	What precautions do you take to prevent infections when providing	1..... 2.....

	LAFP methods?	3..... 4..... 5.....
Q2.41	<p>How do you respond to the following statement:</p> <p>A. I have acquired adequate knowledge and skills required to provide LAFP.</p> <ol style="list-style-type: none"> 1. Strongly Agree 2. Agree 3. Not Sure 4. Disagree 5. Strongly Disagree <p>B. I found the training content useful or relevant to the work I do.</p> <ol style="list-style-type: none"> 1. Strongly Agree 2. Agree 3. Not Sure 4. Disagree 5. Strongly Disagree 	
Q2.42	How comfortable are you in inserting IUCD or Jadelle on clients?	<p>Very comfortable</p> <p>2. Comfortable</p> <p>3. Not sure</p> <p>4. Uncomfortable</p> <p>5. Very uncomfortable</p>
Section C: Attitudes		
Q3.1	<p>What are your personal views about use of long acting family planning methods?</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>	
Q3.2	Do you have any preference in providing a particular type of long acting family planning method?	<p>1. Yes</p> <p>2. No —————> Q3.3</p>
Q3.3	<p>What are the common myths or misconceptions expressed by women seeking long acting family planning services?</p> <p>1.....</p> <p>2.....</p> <p>3.....</p> <p>4.....</p> <p>5.....</p>	
Q3.4	What is your view about each of the myths and misconceptions you have mentioned?	

	1..... 2..... 3..... 4..... 5.....	
Q3.4	How do you deal with these myths and misconceptions? 1..... 2..... 3..... 4..... 5.....	
Q3.5	Do you think clients who come to this facility prefer LAFP methods?	1. Yes 2. No —————> Q3.7 3. Don't know—————> Q3.8
Q3.6	If Yes why do you think they prefer LAFP methods?	
Q3.7	If No why do you think they don't prefer LAFP methods?	
Q3.8	Do some clients choose not to discontinue with the LAFP method?	1. Yes 2. No —————> Q3.10
Q3.9	How common is it for clients on LAFP to discontinue with the method?	1. Very common 2. Common 3. Not sure 4. Uncommon 5. Very uncommon
Q3.10	What are some of the reasons clients who choose to discontinue with the method give?	
Q3.11	What do you think can be done to improve LAFP service provision?	
Q3.12		

<p>How do you respond to the following statement?</p> <p>A. I prefer providing short –term family planning methods to LAFP methods</p> <ol style="list-style-type: none"> 1. Strongly Agree 2. Agree 3. Not Sure 4. Disagree 5. Strongly Disagree <p>B. It is very involving and time consuming to provide LAFP methods:</p> <ol style="list-style-type: none"> 1. Strongly Agree 2. Agree 3. Not Sure 4. Disagree 5. Strongly Disagree 			
SECTION D: OBSERVABLE CHANGES IN LAFP SERVICES			
Q4.1	<p>At your family planning centre, do you think there has been any change in the number of clients utilizing long acting family planning services since you attended the LAFP training?</p> <ol style="list-style-type: none"> 1. Yes 2. No —————> Q4.4 		
Q4.2	<table border="1" style="width: 100%;"> <tr> <td style="width: 50%;">How has the utilization changed?</td> <td> <ol style="list-style-type: none"> 1. Has increased 2. Has reduced 3. No change </td> </tr> </table>	How has the utilization changed?	<ol style="list-style-type: none"> 1. Has increased 2. Has reduced 3. No change
How has the utilization changed?	<ol style="list-style-type: none"> 1. Has increased 2. Has reduced 3. No change 		
Q4.3	<p>Could you briefly explain the reason(s) for the increase or reduction in the number of clients utilizing LAFP services?</p> <p>.....</p> <p>.....</p> <p>.....</p>		
Q4.4	<table border="1" style="width: 100%;"> <tr> <td style="width: 50%;">How many FP clients do you see on average in a week?</td> <td>.....</td> </tr> </table>	How many FP clients do you see on average in a week?
How many FP clients do you see on average in a week?		
Q4.5	<table border="1" style="width: 100%;"> <tr> <td style="width: 50%;">How many of these come for LAFP?</td> <td>.....</td> </tr> </table>	How many of these come for LAFP?
How many of these come for LAFP?		
Q4.6	<table border="1" style="width: 100%;"> <tr> <td style="width: 50%;">On average how many IUCD insertions do you provide in a month?</td> <td>.....</td> </tr> </table>	On average how many IUCD insertions do you provide in a month?
On average how many IUCD insertions do you provide in a month?		
Q4.7	<table border="1" style="width: 100%;"> <tr> <td style="width: 50%;">On average how many Jadelle insertions do you provide in a month?</td> <td>.....</td> </tr> </table>	On average how many Jadelle insertions do you provide in a month?
On average how many Jadelle insertions do you provide in a month?		

Q4.8	Do you have the following commodities at this facility?					
		Available		If No, how long ago?		Reason for not having the commodity
		Ye s	No	Month s	Years	
	1. IUCD					
	2. Jadelle					
	3. Sinoplant					
	4. Implanon					
	5. Pills					
6. Depo Pro Vera						
7. Condoms						
Q4.9	Do you have the following equipment at this facility?					
		Availabl e		If No, How many months ago	Reason for not having the commodity	
		Ye s	No			
	1. Stethoscope					
	2. Blood Pressure					
	3. uterine sound					
	4. Sponge holding					
	5. Dissecting forceps					
	6. curved mosquito					
	7. Straight mosquito					
8. Speculum						
9. Tenaculum/vaselum						
Q4.10	Do you have the following Supplies at this facility?					
		Available		If No, How many months ago	Reason for not having the commodity	
		Yes	No			
	1. Clinical sterile					
	2. Heavy duty gloves					
	3. Sharps container					
	4. Autoclave					
	5. Big receiver/kidney					
	6. gallipot					
	7. Cotton Wool					
	8. Gauze Swaps					
	9. methylated Spirit					
10. Bandages						
11. Lignocaine						
Q4.11	Do you think your facility is ready to provide effective LAFP services?			Yes No → Q4.13		

Q4.12	If Yes why do you think your facility is ready to provide effective LAFP services?	
Q4.13	Why don't you think your facility is ready to provide effective LAFP services?	
Q4.14	What do you consider the biggest strengths for long acting family planning at this centre?	
Q4.15	What do you consider the biggest weakness for long acting family planning at this centre?	
Q4.16	Do you offer HIV and AIDS services at family planning clinic?	1. Yes 2. No ———>Q4.18
Q1.17	Which of the following HIV and AIDS services do you offer at family planning clinics?	1. HIV counselling and Testing 2. PMTCT 3. ART 4. Care and Support
Q4.18	Do you encourage clients to come with their male spouse for family planning?	1. Yes 2. No
Q4.19	Do clients come with their male spouse for family planning?	1. Yes 2. No
Q4.20	How frequently do clients come with their male spouse for family planning?	1. Very Frequently 2. Frequently 3. Occasionally 4. Rarely 5. Never

THANK YOU: END OF INTERVIEW

ZAMBIA INTEGRATED SYSTEMS STRENGTHENING PROGRAM (ZISSP)

RAPID ASSESSMENT OF APPLICATION OF LONG ACTING FAMILY PLANNING
TRAININGS OF HEALTHCARE PROVIDERS

(AUGUST 2013 – OCTOBER 2013)

***Key Informant Questionnaire/Structured Interview for Supervisors of Long Acting Family
Planning Providers Trained by ZISSP/MOH***

(Health Care Provider Supervisors Only)

- All spaces **MUST** be filled in.
- Interviewer Code:

Introduction

Greetings, I am part of a team from the Ministry of Health, (MOH), Ministry of Community Development Mother and Child Health (MCDMCH) and Zambia Integrated Systems Strengthening Programme (ZISSP) that is evaluating the training programme conducted on Long Acting Family Planning Methods. The lead consultant of this study is Prof. Sekelani S. Banda. He has been contracted by ZISSP on behalf of the two Ministries. The results of this evaluation will be used to improve future training on Long Acting Family Planning methods. The report of this interview and other findings will be recorded in such a manner that they cannot be attributed to you and what you say will be kept confidential for your identity purposes. Do you agree to proceed with this interview?

Tick as appropriate: Yes / No

1.0 General Questionnaire Particulars

1.1 Questionnaire ID:

1.2: Province: _____

1.3 District: _____

1.4 Health Facility: _____

1.5 Date of interview: ____/____/____

Serial No.	Question	Response	Entry Code
SECTION A: Demographic Profile			
Q1.1	What is your gender?	Male.....1 Female.....2	
Q1.3	What is your principal professional qualification?	Registered midwife..... 1 Registered nurse.....2 Enrolled midwife..... 3 Enrolled nurse.....4 Medical Officer.....5 Clinical Officer.....6 Other.....7	
Q1.4	How long have you actively worked in supervising family planning services?	Enter	
Q1.5	Have you had any training focused on long acting family planning other than that organized by ZISSP/MOH/MCDMCH?	Yes.....1 No.....2	
Q1.6	If NO skip to Section B; if YES : How many times have you had this training? When was the last time you had the training?	..... Year..... Month.....	
SECTION B: Application of LAFP Training			
Q2.1	What is your response to the statement: The worker who attended the long acting family planning training run by MOH/MCDMCH/ZISSP <i>has put to use</i> what they learned there?	Strongly Disagree.....1 Disagree.....2 Neutral.....3 Agree.....4 Strongly Agree.....5	
Q2.2	What is your response to the statement:	Strongly Disagree.....1 Disagree.....2	

	The worker who attended the long acting family planning training run by MOH/MCDMCH/ ZISSP <i>is now very capable to teach the new knowledge, skills and attitudes</i> about long acting family planning which they learned there?	Neutral.....3 Agree.....4 Strongly Agree.....5	
Q2.3	What is your response to the statement: The professional behaviours with regard to family planning of the worker who attended the long acting family planning training run by MOH/MCDMCH/ZISSP have changed considerably since the training.	Strongly Disagree.....1 Disagree.....2 Neutral.....3 Agree.....4 Strongly Agree.....5	
Q2.4	What is your response to the statement: The work environment is supportive to allow the worker who attended the long acting family planning training run by MOH/MCDMCH/ZISSP to implement the things learned there.	Strongly Disagree.....1 Disagree.....2 Neutral.....3 Agree.....4 Strongly Agree.....5	
SECTION C: Observable Changes in LAFP Services			
Q3.1	At your family planning centre, has the number of women accessing long acting family planning increased? 1. Yes 2. No (Tick) (If yes proceed to Q3.2 if no skip to Q3.3)		

Q3.2	How many FP clients do you see on average in week? Number
Q3.3	How many of these come for LAFP? Number
Q3.4	On average how many IUCD insertions do you provide in a month? Number
Q3.5	On average how many Jadelle insertions do you provide in a month? Number
Q3.6	What do you consider the biggest strengths for long acting family planning at this centre?
Q3.7	What do you consider the biggest weakness for long acting family planning at this centre?
Q3.7	Have there been improvements in efficiency or effectiveness of the services at this centre which you can attribute directly to workers attending the long acting family planning by MOH/MCDMCH/ZISSP?

THANK YOU: END OF INTERVIEW

ZAMBIA INTEGRATED SYSTEMS STRENGTHENING PROGRAM (ZISSP)

RAPID ASSESSMENT OF APPLICATION OF LONG ACTING FAMILY PLANNING
TRAININGS OF HEALTHCARE PROVIDERS

Long Acting Family Planning Facility Checklist

- All spaces **MUST** be filled in.

- Interviewer Code:

Introduction

Greetings, I am part of a team from the Ministry of Health and Zambia Integrated Systems Strengthening Programme (ZISSP) that is evaluating the training programme that the two organisations conducted on Long Acting Family Planning Methods. The lead consultant of this study is Prof. Sekelani S. Banda. He has been contracted by MOH/ZISSP. We are required to see the Long Acting Family Planning facilities and review some documents related to the facility and forward information for reporting. The results of this evaluation will be used to improve future training done by ZISSP/MOH. The report of this exercise will be recorded in such a manner that they cannot be attributed to institution in particular and is seen here will be kept confidential for identity purposes. Do you agree for us to proceed with this procedure?

Tick as appropriate: Yes / No

1.0 General Questionnaire Particulars

1.1 Questionnaire ID:

1.2: Province: _____

1.3 District: _____

1.4 Health Facility: _____

1.5 Date of interview: ____/____/____

CHECK LIST FOR FAMILY PLANNING CENTRES PROVIDING LONG ACTING FAMILY PLANNING SERVICES

	QUANTITY (&Units)		Comments (e.g. reason for non-availability)
Trained Personnel			
• Medical officer	<input type="text"/>	<input type="text"/>	
• Clinical Officer	<input type="text"/>	<input type="text"/>	
• Nurse	<input type="text"/>	<input type="text"/>	
• Midwives	<input type="text"/>	<input type="text"/>	
• Persons specifically trained in long acting family planning methods	<input type="text"/>	<input type="text"/>	
Key Long-term Family Planning Services	Available		
	Yes	No	
• The copper-bearing IUD	<input type="text"/>	<input type="text"/>	
• Progestin Implants (e.g. Norplant2 – Jadelle)	<input type="text"/>	<input type="text"/>	
• Progestin-only injections (e.g. Depo Provera)	<input type="text"/>	<input type="text"/>	
• Progestin/Oestrogen injections	<input type="text"/>	<input type="text"/>	
• Cervical rings	<input type="text"/>	<input type="text"/>	
• Skin patches	<input type="text"/>	<input type="text"/>	
• Tubal ligation Services available	<input type="text"/>	<input type="text"/>	
• Vasectomy Services available	<input type="text"/>	<input type="text"/>	
Counseling /Examination/Procedure Rooms			
• Privacy available	<input type="text"/>	<input type="text"/>	
• Samples of IUD available	<input type="text"/>	<input type="text"/>	
• Samples of implants available	<input type="text"/>	<input type="text"/>	
• Models for explaining procedures available	<input type="text"/>	<input type="text"/>	
• Diagrams/pictorial aids available	<input type="text"/>	<input type="text"/>	
• Examination couch available	<input type="text"/>	<input type="text"/>	
• Thermometer available	<input type="text"/>	<input type="text"/>	
• Scale for weight available	<input type="text"/>	<input type="text"/>	
• Tape for height available	<input type="text"/>	<input type="text"/>	
• Stethoscope available	<input type="text"/>	<input type="text"/>	
• Working blood pressure machine available	<input type="text"/>	<input type="text"/>	
Infection Control			
• Disposal methods	<input type="text"/>	<input type="text"/>	
- Sharps container	<input type="text"/>	<input type="text"/>	
- Refuse bin with covers	<input type="text"/>	<input type="text"/>	
- Heavy duty gloves	<input type="text"/>	<input type="text"/>	
.Clinical sterile gloves	<input type="text"/>	<input type="text"/>	
- Water supply (running)	<input type="text"/>	<input type="text"/>	

• Autoclave			
• Pressure cooker (steam)			
IUD Insertion set			
I big receiver/kidney dish			
1 gallipot			
1 Tenaculum/vaselum			
1 uterine sound			
1 sponge holding forceps			
1 speculum			
IUCD Removal			
1 big receiver			
1 sponge holding forceps			
1 gallipot			
1 crocodile forceps (optional)			
Jadelle Insertion			
1 receiver			
2 gallipots			
1 dissecting forceps			
Jadelle Removal			
1 receiver			
2 gallipots			
1 dissecting forceps			
1 curved mosquito forceps			
1 straight mosquito forceps.			
Record Keeping			
• Patient register			
• Procedure registers			
• Stock cards available and being used			
• Referrals recorded			
• Complications – documented			

Appendix III: Number of interviewees by health facility, district and province

Province	District	Facility	Male	Female	Total	
Central	Kabwe	Makululu		1	1	
		Kapiri Mposhi	Chikupili		1	1
			Chilumba RHC		1	1
		Chipepo		1	1	
		Chitambo	1		1	
		Lukomba RHC	1		1	
		Mahatma Gandhi		1	1	
		Mkushi Hospital	1		1	
		Mpika Urban		1	1	
		Mukonchi RHC		1	1	
		Natuseko HC		1	1	
		Ndeke Clinic		1	1	
		Waya RHC	1		1	
		(blank)	1	1	2	
	Mkushi	Mkushi Hospital		1	1	
		Nshinso RHC		1	1	
	Serenje	Kabamba RHC		1	1	
		Mapepala RHC		1	1	
		Mpelembe RHC	1		1	
		Muchinka	1	1	2	
Mulilima RHC		1	1			
Central Total			7	16	23	
Eastern	Chipata	Chipata General Hospital		1	1	
		Lundazi	Chikomeni RHC		1	1
	Kanyanga			1	1	
	Lundazi District Hospital			1	1	
	Lundazi Urban		1		1	
	Lusuntha RHC			1	1	
	Mwasemphangwe			1	1	
	Nkhanga RHC			1	1	
	Umi		1		1	
	Mambwe		Chikowa RHC		1	1
			Chisengu Hospital		1	1
		Kakumbi RHC		1	1	
		Mambwe DHO		1	1	
	Nyimba	Masumba		1	1	
		Chinambi RHC	1		1	
		Chipempe RHC		1	1	
		Hofmeyer	1		1	
		Kacholola		1	1	
		Mkopeka RHC	1		1	
		Nyalungwe	1		1	
(blank)		1	1	2		
Eastern Total			7	15	22	
Southern	Choma	Njase RHC		2	2	

	R/Surgery		1	1
	Shampande		1	1
Gwembe	Chamwe RHC	1		1
	Gwembe District Hospital		1	1
	Gwembe DMO		1	1
	Lukonde RHC	1		1
Kalomo	Habulile		1	1
	Kalomo DMO		1	1
	Namwianga		1	1
	Nazilongo		1	1
	Zimba Mission Hospital		1	1
Livingstone	Livingstone		1	1
	Livingstone DMO		2	2
	Simonga		1	1
Sinazongwe	Buleyamalima		1	1
	Siansowa		1	1
	Sinazongwe DMO		1	1
	(blank)		2	2
Southern Total		2	20	22
Grand Total		16	51	67

Appendix IV: Study Team and Timetable

Fieldwork Team and Additional Fieldworkers

Central Province Team:

1. Professor Sekelani S. Banda – Consultant
2. Ms. Namukolo Mwangala – Research Assistant
3. Mr. Patrick Engaenga – Research Assistant
4. Ms. Mwiche Nanyangwe -Research Assistant

Eastern Province Team:

1. Lawrence Banda – ZISSP M & E officer
2. Ms. Pheidah Daka – Research Assistant
3. Ms. Marian Namasiku – Research Assistant

Southern Province Team:

1. Ms. Cooley M. Musukwa – Research Assistant
2. Musonda Ngoi – Research Assistant

Project Team & Roles:

1. Consultant – provide project oversight, supervisory and validation visits.
2. ZISSP M & E Officer – arrange appointments, and quality assurance.
3. Research Assistants - administer key informant questionnaires, and complete checklists.

Timetable

	Start	Finish
Research Assistant Training	28/10/2013	30/10/2013
Piloting	31/10/2013	
Pilot Review	01/11/2013	
Fieldwork	3/11/2013	16/11/2013
Data Entry	17/11/2013	24/11/2013
Report Writing	02/11/2013	