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E2A EVIDENCE TO ACTION
for Strengthened Reproductive Health

Training to Improve Quality and Access to Contraceptive Implants in Burundi's Kayanza and Muyinga Provinces

E2A Overview

The Evidence to Action Project (E2A) is the US Agency for International Development's global flagship for strengthening family planning and reproductive health service delivery. The project aims to address the reproductive healthcare needs of girls, women, and underserved communities around the world by increasing support, building evidence, and leading the scale-up of best practices that improve family planning services. A five-year Cooperative Agreement awarded in September 2011, E2A is led by Pathfinder International in partnership with the African Population and Health Research Center, ExpandNet, Intrahealth International, Management Sciences for Health, and PATH.

Contact Information

1201 Connecticut Avenue, NW
Suite 700
Washington, DC 20036
Tel. 202-775-1977
Fax 202-775-1988
www.e2aproject.org

Introduction

Ensuring a wide range of contraceptives that enable clients to exercise their right to choice and meet their reproductive needs, coupled with access to accurate and complete information provided by technically competent service providers, are key elements of quality of care. These elements, when applied together, can result in increased contraceptive use, continuity, and ultimately reduction in the number of unintended pregnancies. This brief describes how the Evidence to Action (E2A) Project provided technical assistance to the USAID-funded Burundi Maternal and Child Health (MCH) Project to address these key elements, improving quality and increasing access to Jadelle contraceptive implants in Burundi's Kayanza and Muyinga provinces.

Background

Burundi is a small, predominantly rural and landlocked country; the population density of 310 people per square kilometer is one of the highest in sub-Saharan Africa, and it ranks among the poorest countries in the world. After almost 13 years of conflict that devastated the country's physical, social, and human capital, Burundi is making progress towards consolidation

of peace and security and improving sector outcomes, particularly in health and education. To improve the health of Burundi's population and environment, along with its prospects for the future, the Government of Burundi has placed a renewed emphasis on expanding and strengthening family planning services. Improvements in health, however, continue to be constrained by the lack of essential medicines, low numbers of qualified health workers, poor infrastructure, and limited financing for health.



The Government of Burundi's policy (2006) of free health care for pregnant women and children under age 5, as well as free family planning services, has increased clinic utilization and the number of women giving birth in health facilities. The maternal mortality rate dropped from 615 per 100,000 live births in 2005 (MICS 2005) to 499 in 2010 (Burundi Demographic and Health Survey (BDHS) 2010). The BDHS 2010 also shows some improvement in the health status of the population. Public health centers are the main source of family planning services, with 75% of the health centers providing over 80% of family planning services countrywide. Despite progress, the fertility rate of 6.4 children among women is high (BDHS 2010); 29% of women have unmet need for family planning, and unsatisfied demand for modern methods of family planning is 33%.

The population of Burundi has nearly doubled over the past three decades: currently it is estimated at 8,053,574, up from about 4 million in the early 1980s. The population is very young, with a high proportion of girls and women in their peak childbearing years. The annual population growth rate of 2.8% per year (Burundi DHS, 2010) is one of the highest in sub-Saharan Africa. One of Burundi's long-term objectives is to reduce the country's total fertility rate from 6.4 to 3.0 children per woman by 2025 through the promotion of FP. The specific goal of the Republic of Burundi Poverty Reduction Strategy Paper II, in relation to FP, is to lower the fertility rate from the current 6.4 children per woman to 5.3 by 2015. According to the most recent BDHS statistics, the modern contraceptive prevalence rate (CPR) is 22% among married women (Measure DHS and ICP Macro 2010). In order to reach the government's goals and meet the unsatisfied need for family planning, in accordance with the Declaration of National Population Policy adopted in October 2011, the Government of Burundi aims to increase the CPR from 22% in 2011 to 40% by 2015.

Burundi's National Family Planning Program

The National Reproductive Health Strategic Plan 2010-2015 includes a goal to increase national modern contraceptive prevalence from 23% in 2010 to 40% by 2015. To achieve this goal, The National Program for Reproductive Health (NPRH) has mobilized partners to support several policies and strategies that include nationwide scale-up of long-acting reversible contraceptives (LARCs), scale-up of community based family planning, task-shifting for provision of injectable contraceptives by health promotion technicians and community health workers (CHWs), and integration of family planning into health programs such as nutrition, immunization, strengthening of mobile outreach and establishment of health posts to offer family planning in hard-to-reach communities. The NPRH includes family planning performance indicators as part of a performance-based financing (PBF) scheme and plans to scale up PBF to include community health workers. The NPRH is implementing several multi-pronged demand generation activities that include: (1) training CHWs to mobilize communities and generate demand for family planning through door-to-door visits and during community events; (2) video shows and local drama; (3) a radio soap opera; and (4) provision of contraceptives during special family planning promotion days. These interventions are yet to be evaluated for effectiveness in generating demand for family planning and LARCs. From a review of records, health facilities that registered a high uptake of implants had a high number of referrals from CHWs; however, the initial awareness could have been from a variety of ongoing demand generation activities.

At facility level, family planning services in Burundi are offered on a daily basis, although services are located in a different room in the maternal health department of the health facility. Service providers conduct client education sessions to generate demand for family planning at child health clinics and refer interested clients. In addition, special health days for primary health care at the community level include family planning services. Health posts, established in hard-to-reach areas, serve to expand the family planning method mix for communities which previously had access only to natural methods through faith-based health facilities.

Currently, only facility-based clinical providers conduct mobile outreach family planning services; however, at times, these are not consistently provided due to a high workload at health facilities. Both facilities and mobile outreach services reach a high number of clients and have the potential to be scaled up. For mobile outreach services to be consistent and responsive to demand, the NPRH may, in the future, consider alternative health workers such as dedicated community outreach family planning providers.

The Burundi Maternal and Child Health Project

The USAID-funded, Pathfinder-led Burundi MCH Project supports the NPRH by addressing the need for quality, community-based, maternal and child health services, and providing information for poor, hard-to-reach, and underserved populations. The project operates in Kayanza and Muyinga provinces, which together are home to a population of 1.2 million people and some of the highest population densities in the country. In Kayanza and Muyinga, the CPR for modern methods among married women is 24% and 22% respectively, which is low compared to 40% in the neighboring province of Ngozi, and 48% in the capital province of Bujumbura (the highest CPR in the country). The main methods provided at the health centers in these provinces are short-acting methods, including oral contraceptive pills (both combined oral contraceptives and progestin-only pills), emergency contraceptive pills, injectable depot medroxyprogesterone acetate (DMPA), and condoms. Among all contraceptive method users, injectable DMPA is the most widely used method; the use of LARCs, such as implants and intrauterine devices (IUDs), has been very low at 3% for IUDs and nearly 0% for implants, due mainly to the limited number of trained health workers available to provide these methods. The NPRH plans to increase the utilization of quality maternal and child health services, including family planning services. The Burundi MCH Project expects to meet the results outlined in the box to the right, specific to family planning.

MCH Project: Selected Expected Results Project

- National family planning/reproductive health (FP/RH) service norms and guidelines revised and disseminated at least in the project's targeted provinces
- National FP curriculum revised, updated, and used by trainers
- All the health centers and maternities in Kayanza and Muyinga (about 86) integrate FP services and at least 50% of them offer long-acting reversible contraceptives—IUDs and Jadelle
- Community-based distribution program revamped in Muyinga and Kayanza
- Couple Years of Protection of 30,000 in each targeted province (50% increase) and increase of contraceptive prevalence by 5 points in each targeted province

E2A Technical Assistance

Contraceptive implants were initially introduced by the International Planned Parenthood Federation affiliate Association Burundaise pour le Bien Familial (ABUBEF) in 2010. ABUBEF and NPRH trained 56 service providers from the seven ABUBEF clinics and selected public sector health facilities to provide implants in 5 out of the 17 provinces in Burundi. In Muyinga, implants were only available at the ABUBEF clinic. In Kayanza, there were health facilities providing implants prior to 2012.

In order to broaden the method mix and increase use of implants, USAID/Burundi provided field support to E2A. That funding supported E2A to provide technical assistance to systematically strengthen the training capacity for implants and work with the Burundi MCH Project to increase access to

implants in Kayanza and Muyinga provinces. This work aligns with E2A's mandate to strengthen family planning/reproductive health services to increase use of family planning services.

E2A's technical assistance built upon the Burundi MCH Project's support to NPRH. The project had already supported revision of the national policy and norms on reproductive health; trained providers on healthy timing and spacing of pregnancy (HTSP) and IUDs; trained CHWs to provide family planning, youth-friendly services, and preventative gender-based violence (GBV) services; and supported the establishment of integrated mobile outreach services in hard-to-reach areas. The project also supports the health management information system and the Ministry of Health's (MOH) PBF activities.

E2A, in collaboration with the Burundi MCH Project, designed and implemented activities to meet the following objectives: (i) develop a Facilitators' Guide on insertion and removal of implants; (ii) train master trainers to implement the guide; (iii) train service providers from Kayanza and Muyinga on insertion and removal of implants; (iv) develop job aids on implants for use by community-based distributors (CBDs) and health facility providers; (v) provide ongoing technical assistance to ensure continued provision of high-quality family planning services; and (vi) provide technical assistance to document the process and outcomes to inform scale-up. The Facilitators' guide, trained trainers, job aids for CBDs, strengthened referral system, and documentation of lessons learned from these activities will be applied to the development and implementation of a systematic scale-up strategy for implants.

Initial Assessment

E2A conducted an assessment in April 2012 to better understand the service delivery context, existing national policies and guidelines on family planning (particularly long-acting methods), contraceptive logistics, supervision, the health management information system, training capacity (including the availability of skilled trainers), as well as available practicum training sites, training materials, and training venues in Bujumbura, Muyinga, and Kayanza. The E2A team of two senior technical staff and a clinical training consultant were accompanied by a focal point person—a technical advisor—from the Burundi MCH Project, who oversaw the technical assistance, led in-country planning, and liaised with NPRH. The E2A team and the Burundi MCH Project technical advisor/focal point briefed USAID, the PEPFAR team leader, the director general and director of the NPRH, monitoring and evaluation officers for the NPRH (MOH), UNFPA, provincial health management teams, district supervisors, ABUBEF staff, and service providers from the public health facilities.

Provincial health managers from the two provinces advised the team to visit ABUBEF clinics; Kayanza and Matongo health centers in Kayanza, and the Muyinga Hospital maternal and child health/family planning clinic and Kiyanza health center in Muyinga, as potential practicum training sites. All of these health facilities have high client volumes for family planning, availability of at least two staff trained in family planning (at least one of whom is trained on IUD insertion), as well as available equipment and good infrastructure. The team conducted an assessment of the capacity and quality of family planning services at the selected health facilities to determine their suitability to serve as practicum sites. Through observation, a review of health facility registers, and interviews with service providers, this assessment included ascertaining: the availability of a variety of maternal and child health, GBV, and youth-friendly services offered; client flow; family planning integration with other maternal and child health services; family planning services offered; availability of family planning policies, guidelines, and job aids; family planning service providers trained; and available equipment needed to provide implants. The team also assessed: infection prevention procedures; logistics; health information management and supervision systems; infrastructure; demand generation activities for family planning; client load; availability of CBDs in the health facility catchment areas; and referral linkages between CBDs and health facilities. The main findings and issues established during the assessment were as follows:

Policies and guidelines: National family planning and reproductive health policies allowed nurses to insert and remove implants. The guidelines were, however, not available at the health facilities. All the health facilities had a wall chart in the local language, *Kirundi*, which contained information on all family planning methods. Service providers referred to the wall chart as a job aid for counseling clients about informed choice of family planning methods. CBDs also used this same wall chart. Some of the health facilities also had flipcharts on family planning.

Variety of services offered: All facilities offered maternal, newborn, and child health services, and nutrition, HIV counseling, sexually transmitted infection, and family planning services. ABUBEF and Kayanza health centers provided youth-friendly sexual and reproductive health services; one provider at Kiyanza Health Center in Muyinga is trained to provide GBV services. Maternal and child health services are offered in separate service areas by different providers with referrals across different service areas as necessary. The public sector facilities and ABUBEF conduct integrated mobile outreach services at health posts and in hard-to-reach and underserved communities.

Health workforce: The average number of staff trained to offer family planning services at the public sector health facilities ranged between two and three, with at least one trained to offer IUDs. One service provider at Muyinga Health Center is trained to manage GBV. One service provider at the Matongo Health Center in Kayanza is trained to offer implants.

Training capacity: The NPRH and ABUBEF started training providers on implants in late 2010. The trainers used a training manual (set of Powerpoint presentations) and a video in English on insertion and removal of implants. The manual was theoretical and did not include guidelines and tools for practicum training. The manual had limited application of competency-based training, which would ensure that participants acquire the necessary competencies to provide quality family planning services including implants. ABUBEF, however, did have the implant insertion and removal mannequin for practice. Kayanza and Muyinga had experienced trainers who have trained service providers on HTSP and IUD insertion, CHWs on community-based distribution of family planning, and other maternal and child health service provision.

Method mix: All facilities offered oral pills (combined pills, progestin-only pills, and emergency contraception) and injectable DMPA. Only one health facility (Matongo) in Kayanza offered implants. DMPA was the most popular method used by clients. Service providers stated that the number of clients who chose implants after counseling was high. These clients were referred to ABUBEF and the few clinics that offered implants. Clients who opted for tubal ligation were referred to the hospitals. There did not appear to be a mechanism to track referrals.

Demand for family planning services: Demand was generated at community level and health facility levels. The NPRH has developed communication messages and materials, as well as conducted mass media campaigns and organized for local theater outreach on family planning. ABUBEF and each public sector health facility in Kayanza and Muyinga provinces had a network of CBDs who resupplied oral pills and initiated condoms to clients, conducted education sessions, counseled clients, and referred clients to the health facilities for contraceptives. The CBDs were supervised by health promotion technicians. The very high client load at child health clinics, nutrition, and postnatal clinics was seen as an opportunity for client recruitment within each facility.

Client load: The number of family planning acceptors was fairly high, with an average of 25 new acceptors per month at all four public sector health facilities in Kayanza and Muyinga. Client load for implant insertions at ABUBEF Bujumbura averaged 60 new acceptors per month. At Matongo Health Center, uptake ranged between 10 and 15 clients per month. ABUBEF had, on average, 5 to 10

removals per month; most of these were said to be clients who received the method from neighboring countries. The most common reason for early removal was heavy bleeding, management of which was noted as needing to be emphasized during training.

Equipment: Each of the health facilities had adequate equipment for family planning, including for IUD insertion. The examination couches did not have the extension arm rest. The team was assured by MCH Project staff that appropriate couches and additional equipment had been procured and would be available by the time of the training.

Logistics: Family planning supplies and commodities were obtained from the provincial medical directorate's office and there seemed to be both a "pull" (where the type and amount of stock is determined and requested by the receiver) and a "push" (whereby the type and amount of stock is determined by the sender) system in place. The health facilities mentioned that they had never experienced any stock-outs of contraceptives. Contraceptives were free to clients in both public and ABUBEF clinics. The MCH Project ensured availability of contraceptives during their routine supportive supervision activities in the health facilities.

Record keeping: All clinics, including ABUBEF, use standard family planning client and clinic records. The family planning daily activity register collected information on new and old acceptors by type of method, the quantity of contraceptives distributed, and the number and type of side effects observed by method. The registers also disaggregated data by sex, age, and parity. The quality of record keeping was verified quarterly by the NPRH as part of the national PBF system. Facility providers mentioned that they had reviewed their monthly returns; if there was a drop observed in number of new acceptors, the facility would request that the CBDs conduct more client education sessions and follow up with clients who did not return for scheduled return appointments to the health facilities. CBD data were shared with the facility staff during monthly meetings with both facility providers and CBDs.

Supervision: The District Health Management Team supervises the health facilities on a monthly basis using a standard comprehensive supervision tool for all services, including family planning, which was developed by the NPRH. The MCH Project also provides direct supportive supervision to the health facilities to strengthen service delivery, provide support for PBF, and to strengthen the health management information system. The supervision does not appear to have included observation and documentation of providers' skills.

Development of Facilitators' Guide on Insertion and Removal of Implants

E2A worked with a clinical training consultant, who was paired with the Burundi MCH Project focal point person; in consultation with NPRH, they developed the Facilitators' Guide from April to May 2013. Selected family planning materials from NPRH, on topics such as counseling and infection prevention, as well as resource materials on competency-based training and implants from E2A, were adapted to develop the guide. This ensured consistency with training materials that had been used locally, inclusion of state-of-the-art contraceptive technology, and application of competency-based training approaches. The Facilitators' Guide included knowledge and skills on: (1) principles of adult learning; (2) use of competency-based training methods; (3) planning, evaluating, and documenting training; (4) physiology of the female reproductive system; (5) characteristics of Jadelle implants; (6) counseling skills for voluntary informed choice; (7) screening clients for eligibility of implants; (8) insertion and removal of Jadelle implants; and (9) infection prevention. To bridge the gap identified on lack of guidance for practicum training, E2A set practicum training objectives and targets. The guide specified that each participant would be required to practice counseling through role play and provide counseling to at least 10 clients, insert and remove an implant on the mannequin 10 times, and perform 8 insertions with clients. Participants would also be required to practice by using role play and demonstration and return demonstration of selected procedures such as counseling, insertion and

removal of Jadelle implants, infection prevention procedures, and facilitating sessions with peers. The guide also included a pre- and posttest on family planning knowledge and competency-based training, as well as learning guides/skills assessment checklists¹ on counseling, screening clients for eligibility, insertion and removal of implants, and infection prevention. The guide was reviewed by USAID Burundi MCH staff and E2A, and revised with extensive feedback provided. E2A procured an implant insertion mannequin arm for classroom practice.

Validation of Trainers' Guide

The MCH Project focal point person organized and facilitated a two-day workshop in June 2012 to validate the Facilitators' Guide. Participants included staff from NPRH and ABUBEF, as well as provincial or district managers, family planning service providers, and family planning trainers from the five provinces that were already providing implants (including Kayanza and Muyinga). Recommendations made by the validation team included the need to produce participant handouts on basic counseling standards for implants specifically, more time for clinical training, and to include a list of resources used to develop the guide. The training schedule was revised to increase practicum training by one full day. Sessions such as an overview of the training and introductions were reduced to accommodate an increase in practicum training. E2A addressed the recommendations from the validation workshop to finalize the guide and prepare participant handouts in time for the Training of Trainers (ToT). Participation of NPRH in the validation and approval of the Facilitators' Guide as a national MOH document fostered country ownership of the guide.

Training of Trainers

In July 2013, E2A implemented the ToT using the Facilitators' Guide to train 15 trainers, 4 each from Kayanza and Muyinga, and 7 from Gitega, Makamba, and Ruyigi provinces, at the request of the NPRH. The participants from Kayanza and Muyinga provinces were selected from among a pool of supervisors and service providers who had previously been trained as trainers or conducted training on family planning. This enabled the training to focus more on development of competencies related to training on and insertion of implants. The 10-day training was therefore divided into 3 days of classroom theory and practice, and 7 days for a clinical practicum. The MCH Project and NPRH provided classroom facilities. Practicum training was conducted at ABUBEF Bujumbura. The E2A clinical consultant and the MCH focal point person assessed health facilities in Kayanza and Muyinga for readiness to be used as practicum training sites. However, the facilities were not used due to unavailability of providers trained on implants to guide acquisition of skills, and therefore required a trainer to be present. The health facilities in Kayanza were used towards the end of the training for the participants who had been assessed as competent by the lead trainer and could continue to practice with peer-to-peer support using the skills assessments checklists on counseling, insertion and removal of implants, and infection prevention. Peer-to-peer support during the practicum training provided participants with the opportunity to practice and improve their coaching skills as well as give/receive feedback. A written pretest, posttest, and evaluation of the ToT were all administered to the participants to demonstrate changes in knowledge and skill acquisition. Additional support was provided during the weekend (midway through training) to participants who needed extra help. At posttest, trained participants scored between 85% and 97% on their tests. The ToT imparted skills on planning, implementing, monitoring, and evaluating training with emphasis on use of competency-based training methods and skills for the insertion and removal of implants. The training team included one obstetrician/gynecologist from the University Teaching Hospital as well as ABUBEF service providers who had previously conducted training on implants. This same

¹ Learning guides/skills assessment checklists are used in training to assist the participant to learn the correct steps and sequence of performing a procedure and to assess progress in skill acquisition towards competency.

team guided skill acquisition during practicum training. The training appeared to have built capacity for training at provincial level, based on feedback from participants.



“The training was very good, it made me confident to train others and also insert and remove Jadelle [implants]. Even the service providers we have trained are confident; we have not had any problems”.

- Trainer, Muyinga Province

Training of Service Providers

E2A supported the newly trained trainers during initial training of service providers in Kayanza and Muyinga, specifically during the three-day classroom theory and practice. The three back-to-back training workshops, two in Muyinga and one in Kayanza, were conducted between August and September 2012. The five trainers from each province conducted the training as a team. Practicum training of service providers was held at Gakenke, Kayanza, and Rukago health centers in Kayanza and at Gitaramuka, and Munagano health centers in Muyinga. The health facilities were selected based on their high uptake of implants after the ToT. Thirty service providers were trained by the Muyinga team and fifteen by the Kayanza team. Pretest and posttest questionnaires with a posttest minimum score of 85% were administered during the training to assess knowledge acquisition. The average increase in knowledge acquisition ranged between 15 and 25 percentage points. Trainers also used the learning guides/skills assessment checklists to observe and guide each participant to counsel at least five clients on voluntary informed choice of family planning including implants, and to insert the Jadelle implant at least 10 times in the mannequin. Afterwards, participants received a guided practice session whereby they were required to insert Jadelle in a minimum of seven clients. After a participant reached the required practicum objectives, trainers used a participant skills checklist to assess whether the participant had reached the desired level of competence.



According to training reports from the ToT and from the two initial trainings for service providers, over 300 clients received Jadelle insertions during practicum training, indicating a high demand for implants. The high client volume ensured that each participant had an adequate amount of practice to reach the required level of competency for insertion of Jadelle. However, participants were only able to practice removals of Jadelle on the mannequin arm (as well as through observation of trainers), as Jadelle was newly introduced and demand for removals by clients was low. Further training will be required for participants to develop adequate skills for implant removal.

Supportive Supervision

The supervisors who were trained as trainers integrated supportive supervision of implant provision in their routine monthly supervision visits to health facilities as part of quality assurance. Quality assurance was enhanced by the Burundi MCH Project's focal point person for implant expansion, who conducted post-training follow-up, provided on-the-job support to the trained service providers, and worked to ensure consistent supply of implants, supplies, and equipment at the health facilities. This support enabled the service providers to start offering implants to their clients immediately after training. During one of E2A's technical visits to Burundi, E2A offered guidance to the district supervisor/trainers to use the assessment checklists in the Facilitators' Guide. Those checklists can be used to assess and document the skills of trained providers at least annually to ensure providers' retention of skills and competence to provide quality services, as well as to identify needs for refresher training.

Documentation to Support Scale-up

E2A, through its core partner the African Population and Health Research Center (APHRC), developed activity reporting forms and monitoring tools that were used to document the process and outcomes of each step taken towards expanding access to implants. E2A APHRC staff maintained contact with the E2A consultant and Burundi MCH Project focal point person during and after the development of the trainers' guide, ToT, and training of service providers to ensure documentation. Additional information documented included service statistics at the facilities where a service provider had been trained with E2A support.

E2A completed an activity reporting form after the implementation of each activity. The MCH Project reviewed training reports and completed project reports to track progress and outcomes. Immediate virtual support was provided as required. A two-week data gathering exercise in February 2013 ensured additional data for documentation. Interviews were conducted with respondents (national-level trainers, service providers, and clients). Key information collected included: (1) the process undertaken to develop and validate the Facilitators' Guide; (2) the process of implementing the ToT, including selection of trainers and practicum training sites; (3) the experiences of service providers in providing Jadelle; and (4) the views of acceptors on their satisfaction with Jadelle implants. The documentation included a review of clinic family planning registers to track service data on new acceptors for family planning, as well as uptake of implants by age and method discontinuation from January 2012 to June 2013.

Follow-up Technical Support

Based on initial service statistics (showing a high demand for implants) and contraceptive forecasting analyses, the Government of Burundi procured a 12-month supply of 100,000 Jadelle implants for 2013. The E2A team conducted a technical assistance visit to Burundi to explore whether clients' demand for implants will likely be sufficient for the country to utilize the quantity procured. The E2A team met with the NPRH Director and other NPRH staff, UNFPA, and other stakeholders to review mechanisms for increasing access to implants, increasing demand in Kayanza and Muyinga provinces, and systematically scaling up to other provinces while ensuring voluntary informed choice and high-quality family planning service provision. E2A complemented the foundation of training by undertaking the following:

- **Development of a job aid on myths about implants:** During a follow-on visit to Burundi, the service providers, CBDs, and MOH counterparts expressed need for development of a job aid that could be used to dispel myths and misconceptions which hinder some women from accepting Jadelle or lead to early removal. E2A staff compiled common myths and misconceptions about implants and how to address these myths during counseling and outreach. These myths and misperceptions were gathered from various sources and used to develop a draft job aid for service providers in Burundi. During a visit to Burundi, E2A verified these common myths and misconceptions about implants with groups of CBDs and health promotion technicians, service providers, supervisors' trainers, and other stakeholders at ABUBEF in

Bujumbura, Kayanza, and Muyinga. A final draft was developed and shared with the NPRH for review and validation. The NPRH requested that the job aid cover myths about all methods. The job aid was translated into Kirundi and the MCH Project finalized it in collaboration with other partners such as UNFPA.

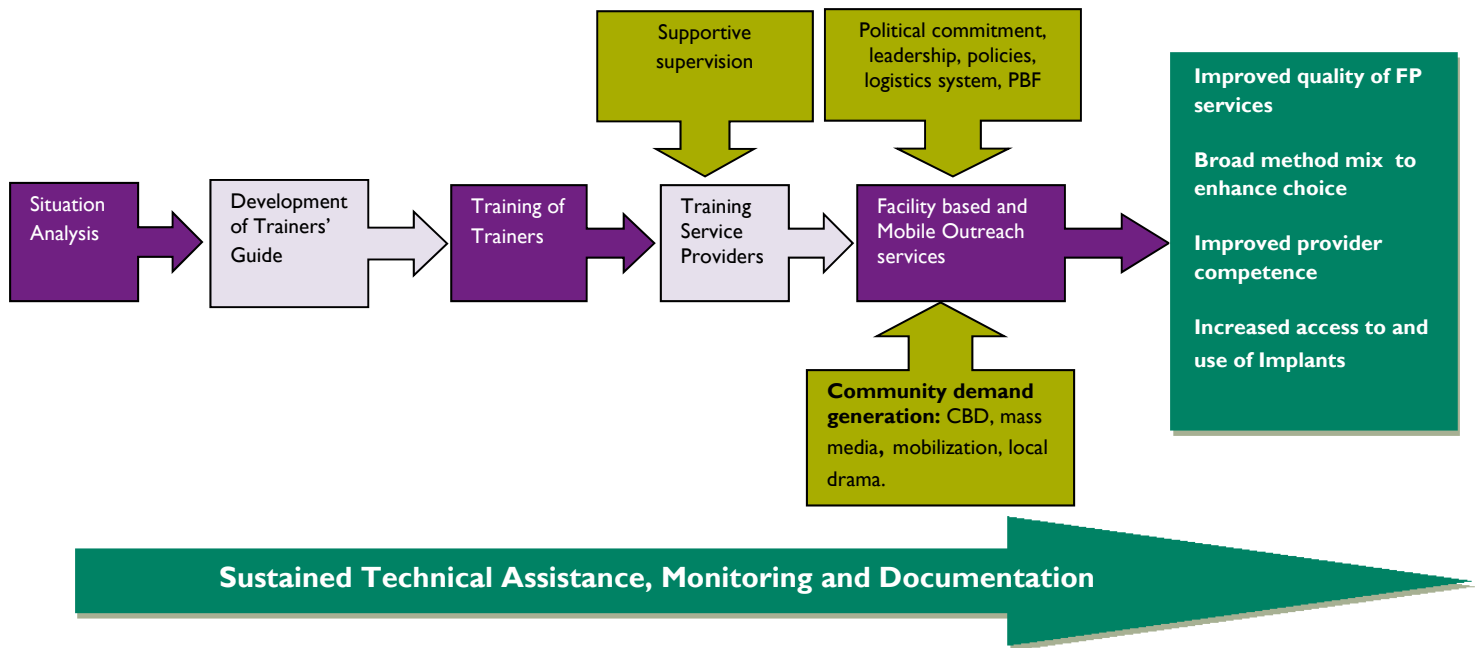
- **Review of training, counseling and infection prevention practices:** E2A interviewed supervisors and trainers to establish whether the training adequately prepared the service providers to counsel and use job aids in order to ensure voluntary informed choice of implants among clients. It was reported that health facilities and CBDs use a wall chart in Kirundi that has information on all methods. The E2A team also reviewed family planning registers to identify the number of implant acceptors. The team asked the service providers, supervisors, CHWs, and community-based family planning distributors for their reasons why the contraceptive implant is such a popular method that some clients are opting to switch from other contraceptive methods. The service providers mentioned that the implant was preferred by clients because it is convenient and does not require follow-up unless one is having problems. Heavy bleeding was reportedly a major cause for removal of implants at ABUBEF; however, as of the August 2013 follow-up visit in the E2A-supported Kayanza and Muyinga facilities, heavy bleeding, which was managed as per guidelines, had not emerged as an issue for removal, thus enabling clients to continue using the implants.
- **Strengthening referral linkages between CBDs and health facilities:** The Burundi MCH Project had a system whereby CBDs and health facility staff met monthly to share client data and address any family planning-related issues. CBDs received a resupply of pills and condoms at these monthly meetings. E2A felt that this system should continue to be supported; however, there was a need for the system to track successful referrals by CBDs at the health facility level. This would ensure that clients who have expressed an interest in a family planning method at the community level receive a method of their choice from the health facility. It would also ensure that clients initiated on oral pills at the health facility are referred to the CBDs for resupply and continue to receive supplies from the CBD. At the time, the Burundi MCH Project monitoring and evaluation staff was working with NPRH to review the health management information system. E2A seized this opportunity to improve the health management information system by providing samples of templates to track referrals between CBDs and health facilities. The system involves use of a referral card system whereby the CBD gives a referral card to the client to take to the health facility; the client then returns to the CBD after he/she has been seen at the facility. This system was adapted by the NPRH to strengthen referrals between CBDs and facilities.

Further Use of the Facilitators' Guide

E2A adapted the Facilitators' Guide for use by supervisors and trained providers to offer cascade training of implant service provision. An on-the-job training guide was developed and contains background information about implants and use of the skills checklist in the Facilitators' Guide. Trainers may conduct skills assessments to ensure that participants from the on-the-job training have attained required practical and national competencies.² Implementation of the on-the-job training guide will contribute to the standardization of on-the-job training, increasing the number of providers with skills to insert and remove implants at each facility. This, in turn, has the potential to improve access and continuity of service provision. For the national program, this can contribute to the sustainability of the training. The guide is under review and will be submitted to NPRH for validation.

² National policy and standards mandate that the National Program for Reproductive Health must assess and certify that individual training participants are competent to insert Jadelle implants independently.

Summary of E2A Technical Assistance Implementation Environment



Results

After the service provider's training, public sector health facilities in Kayanza (28) and Muyinga (43) were offering a broad range of short- and long-acting contraceptives (except for permanent methods).³ This has given more women in rural Burundi the ability to choose a method and have control over their fertility, which can result in life-saving benefits. As shown in Table I (on the next page), monthly data compiled by the Burundi MCH Project from all facilities in the two provinces (and submitted to the MOH) showed a high uptake of implants; the number of implant acceptors in Kayanza and Muyinga increased five-fold in the first six months of 2013, compared to the same time period in 2012 (from 1,782 in 2012 to 9,316 in 2013). These data show that after just one year, implants have emerged as the third most accepted FP method (12% of acceptors), after injectables (72%) and oral pills (13%). Other less popular methods included the IUD (3%), the male condom (1%), and natural family planning (0.4%). Providers and CBDs mentioned that their clients prefer the implant as it is a long-acting method that does not require frequent visits to the health facility—a big advantage for a population whose livelihood depends on subsistence farming. Family planning service data from the health facilities in Kayanza and Muyinga reveal a wide difference in uptake of Jadelle among health facilities: from an average of 50 clients per month in high-performing facilities to less than 0 or 1 per month in low-performing facilities (data not shown).

³ Training on permanent methods has not been offered in Kayanza or Muyinga.

Table 1: Number and percent distribution of new acceptors of family planning methods in Kayanza and Muyinga Provinces of Burundi, before training (January-June 2012) and after training (January-June 2013)

Type of Method	January-June 2012		January-June 2013	
	Total Acceptors	%	Total Acceptors	%
Injectable	62,465	78.6	53,414	71.5
Oral Pills	10,293	12.9	9,316	12.5
Jadelle Implant	1,782	2.2	8,697	11.6
IUD	3,297	4.2	1,851	2.5
Male Condom	1,013	1.3	1,079	1.4
Female Condom	50	0.1	54	0.1
Natural FP (Cycle Beads)	540	0.7	292	0.4
TOTAL	79,440	100.0	74,703	100.0

While data show an increase in new acceptors for Jadelle implants, they do not show an actual increase in the total number of new acceptors for all family planning methods. While the reason for this decline in family planning uptake in Kayanza and Muyinga is not clear, data obtained from one health facility in Kayanza showed that of the 2,946 Jadelle insertions between January and June 2013, there were over 600 switchers from injectables to implants. This situation needs to be closely monitored to see if this trend continues in 2014.

Lessons Learned and Implications for Scale-up

- The systematic introduction and expansion of Jadelle implants in Kayanza and Muyinga provinces, and the resulting increase in the number of implant acceptors, is a reflection of a high demand for implants among women in Burundi and the need for facilities to offer a full range of methods to women. This also provides a good indication for the need to scale-up to other provinces while using service data and information from training and supervision to ensure that family planning policies, strategies, and guidelines keep up with the changes in demand for family planning and service delivery needs.
- While data show increasing acceptors of Jadelle at health facilities, between pre- and post-training in the two provinces, they do *not* show an actual increase in the total number of new acceptors for family planning methods. This situation will require close monitoring and possible design of a demand-generation intervention to reach women with an unmet need for family planning.

- Jadelle implants were available in all public sector health facilities in Kayanza and Muyinga provinces within one year after training. However, some of these facilities stopped providing implants due to transfer of staff to other provinces, which interrupted service provision and made it necessary to train new providers. In order to ensure continued access to implants, at least two providers at each facility must be trained to provide implants and IUDs, possibly by formalizing a system of on-the-job training by trained supervisors, trainers, and service providers. Trainers transferred to other provinces provide an opportunity to expand availability of services if their skills are recognized and equipment is provided in their new facilities, as well as an opportunity to ensure that trained providers maintain their skills.
- As provision of implants is scaled up and number of users increases, there will be a corresponding demand for removals, particularly as some women reach the five-year limit of effectiveness or opt to discontinue method use. As the method was just being introduced at the time of training, there were few removals, and thus few opportunities to allow for adequate skill development in removals. Thus, it will be necessary for NPRH to plan for training on removals of Jadelle implants. NPRH is aware of the need to conduct training on removals and is in agreement that this training will be provided as need arises.
- Resources for additional training are now fully developed and in place, including the Facilitators' Guide, a pool of trained trainers on insertion and removal of implants, job aids, and strengthened linkages between CHWs and health facilities. Adequate preparation of trainers and support to the trainers and supervisors will be necessary to ensure a high quality of training and service delivery.
- The success of training to broaden the family planning method mix and to increase the utilization of implants was enhanced by commitment and leadership support from NPRH, by community-based demand-generation activities, linkages between CBDs and health facilities, and a PBF system, as well as by supportive supervision and ensuring availability of commodities and supplies. In addition to making sure these factors are in place, a systematic scale-up strategy should be informed by data on service utilization in order to ensure that the package of interventions being scaled up addresses the reason for low utilization of some methods, whether due to limited access to information about all methods among clients, client or provider bias, stock-outs, or for other reasons.
- Demand-generation activities conducted through mass media and CHWs, may have contributed to increasing access to implants in Kayanza and Muyinga, and should be considered as part of the scale-up process. Developing training capacity at the provincial level including development of trainers, practicum sites, supportive supervision, and ensuring continuous availability of supplies and commodities are other critical factors in need of consideration for scale up.

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