Providing Evidence for Policy Review: Lessons Learned From Nigeria Pilot Project on Community-Based Access to Injectable Contraceptives

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CBA: History in the Making

1970s
Bangladesh

1990s
Latin America

2004
Uganda

2006
Madagascar

2009
Nigeria
Kenya

FHI 360

USAID
CHAIN
NURSEAGS

FHI 360
THE SCIENCE OF IMPROVING LIVES
Rationale: Nigeria’s RH Profile

- Population........... 167 Million
- TFR......................5.7/ woman
- CPR (All methods)...........15%
- Unmet Need FP ....20%
- Unintended Preg.....4%
- Mistimed Preg.......7%
- HIV Prevalence......4.1%
- PLWH .... ......................F>M
- 1 in 3 women experiences difficulty with transport: major barrier to accessing care
National RH Policy constraints

• Injectable contraceptives provision only by trained medical professionals and in health facilities

• But...... task-shifting occurs in practice without policy backing
Program Intervention

- A study tour to Uganda in February 2008 to learn from Uganda’s implementation and scale-up of CBA.

- Dissemination of the study tour report to the Nigerian National Reproductive Health Working group (NRHWG)

- The NRHWG approved a policy change to allow Community Based provision of injectable contraceptives by CHEWs

- Task-shifting to non-medical professionals was not approved

- Training, Community Engagement and Mobilization, Male involvement.
Methods

- Pilot was conducted between Oct. 08 to Feb. 10 in two rural communities in North East Nigeria, to demonstrate feasibility of CBA in Nigeria

- Data was collected using a specially designed tool recording clients’ demographic data, type of FP commodity provided and complications.

- FP commodities were provided by the CBA pilot at the same user fee as in the clinics

- Paired *t* test was used to compare mean couple years of protection (CYP) on commodities dispensed in communities with that for FP clinics serving the same population
• A total of 2,363 clients (329 males and 2034 females) were reached through community-based services (injectables and other contraceptives) in the pilot LGAs.

• Clients reached were in the age groups of 25–34 years (55%), 15–24 years (25%), and 35-44 years (18%).

• Community-based services yielded a significantly higher mean CYP for all methods compared to facility-based service.
Lessons Learned

• CBA is feasible and can complement facility-based access in Nigeria

• CBA appears promising in increasing FP uptake particularly where utilization of services is low and in rural and hard-to-reach populations

• Operational research comparing CBA cost and safety of delivery by CHEWs compared to CVs will provide evidence for future policy review

• To overcome FP barriers and challenges, policies need to be dynamic and respond to available evidence
Acknowledgements

• USAID
• Government of Nigeria
• Federal Ministry of Health, Nigeria
• Gombe State Government
• Pilot Communities: Funakaye and Yamaltu/Deba
THANK YOU ALL FOR YOUR ATTENTION