Process Evaluation of the Introduction of Community-Based Provision of Family Planning Services

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Community Health Worker (CHW) Program in Rwanda

- Base of health care system
- 4 CHWs in each village = 60,000 in total
  - *Binome* is two CHWs (one male, one female)
    - Responsible for children >2 years and families
    - Community-based integrated management of childhood illness (IMCI)
  - Maternal health CHW
    - Follow-up of pregnant women and infants
  - Social affairs officer
    - Community sensitization
Policy on community-based provision of FP services (CBP)

- CHWs are authorized to provide resupply to current users of:
  - Injectables
  - Oral contraceptive pills
  - Standard Days Method
  - Condoms
- All methods must be initiated by a provider in a health post, health center or hospital
- CHWs are supervised by a Community Health Supervisor at each health center
- Services commenced in December 2010
CHW training in FP services

- Trained 3061 Community Health Workers in 3 districts
  - (August – November 2010)
- Two CHWs (*binome*) of the 4 in the village were selected by the CHW supervisor
- Training is 8 days + practical sessions
- Certification process for provision of injectable contraceptives:
  - Theory, practice and observation
  - 63% of CHWs received certification on first try
Evolution of FP service provision in three districts in Rwanda, December 2010-September 2011, by method

- Cycle beads
- Condoms
- Pills
- Depo provera

[Bar chart showing the evolution of FP service provision in three districts in Rwanda, December 2010-September 2011, by method.]
Process Evaluation Objectives

Evaluate first seven months of service provision.

1. Ascertain CHW and Community Health Supervisor satisfaction with the training they received
2. Document barriers and facilitators of service provision
3. Generate recommendations for scale-up of CBP of FP to other districts
Methods

Focus group discussions with:

- Community Health Workers
  - 2 facilities randomly selected in each district
  - Supervisors requested to recruit 10 CHWs who:
    - Participate in the CBP Program
    - Well-spoken
    - Mix of high and low performers
- Community Health Supervisors
  - Supervisors from 6 randomly-selected facilities in each district
Training

• Selection of who will be trained is key
  – CHWs should be of reproductive age themselves

• Practical sessions of the training were acknowledged to be the most important (especially for injectables) and the most complicated to organize

• Want longer training and more time in supervised practice

• Should be trained to give counseling on all methods, not just those they can provide
Introducing the service

- Official introduction (launch) of the program and the trained CHWs is important to garner community support and confidence in the service
  - Political and local leaders’ buy-in essential
  - Public ceremony for certification
Community acceptance

• Strong perception that clients are satisfied with the service
  – Saves clients time and money to have services available in the community
  – Some reported it was more discrete to get a method from a CHW than the health center

• Support of local authorities important
  – Allowing CHWs to speak at community meetings

• No differences noted between acceptance of male and female CHWs

• Some religious barriers still exist
Perceived competence

• CHWs and supervisors confident in the quality of their services
  – No complaints from clients
  – No method failures
  – Clients came back to CHWs after first visit
  – No reports of complications

“At the beginning of the training it was hard to understand, but after the training I had confidence in myself because among my 53 clients no one indicated any problem.” – CHW
Perceived competence, continued

• Challenges with some methods:
  – Standard Days Method complicated to counsel on
  – Difficulty in drawing all of the injectable suspension
  – Dual method use counseling lacking

• Provision of calendars may help organize resupply visits
Equipment and supplies

• Occasional stock-outs of methods and supplies
  – CHWs often live far from the health center that resupplies them
    • Are required to pay for their own transport
  – Receive small numbers of commodities and supplies
  – Lag in commencement of activities due to no supplies
• CHWs lacking materials or products often refer the client to another CHW in the same area
Supervision

• Most CHWs had received at least one supervision visit

• Import of supervision visits taking place in the CHW’s home/village
  – Strengthen the CHW’s skills
  – Reinforces the credibility of the CHW in the eyes of his/her community

“The importance of supervision is that it compares perhaps to a new training because the supervisor reminds me what I had forgotten. Another important element is that it increases the people’s trust towards me; there is assurance that I am implementing a government program.” – CHW
Barriers

• Delayed start of program after training due to lack of equipment

• Insufficient time during practical training; difficulty in finding enough injectable clients to achieve certification

• Stock-outs because they receive a small quantity of supplies and have to go to the health center to resupply, but they are not given transport funds
Facilitating factors

- Local authority buy-in, including allowing CHWs to sensitize the community during community meetings (e.g., umuganda)
- Referrals from health centers to CHWs
- Supervision not only improves skills, but also reinforces CHW reputation in the community
Next steps

• National scale-up in process
  – 14 additional districts in 2011
    • 2105 trained so far in 2011
    • 88% certified for Depo Provera
  – Complete 17 districts by June 2012
  – Cover the whole Country by June 2013

• Program modifications
  – Only one member of the binome trained in future districts
  – Number of units provided per CHW will be determined by the FP health provider according the 2 last months consumption
Thank you
Merci
Murakoze cyane
Scaling Up the Community-Based Access to Injectable Contraception in Afghanistan
Scaling up Community-Based Family Planning

• Designed based on successes and lessons learned from the Accelerating Contraceptive Use Project

• Scaled-up at village level to 13 USAID-supported provinces first, and then to the remaining parts of the country

• Jointly implemented by the MoPH CBHC and FP Dept. with technical & financial support of MSH/TS and Jhpiego
Community support
- Involve *Shura-e-Sehie* (Community Health Councils)
- Family Health Action Groups

Birth spacing promotion
- Culturally appropriate
- Correct misconceptions

Access to female CHWs

Skilled CHWs
- DMPA counseling
- Technical competence in providing DMPA
- Community maps

Contraceptive choice
- DMPA first injection

Train volunteer CHWs to provide access to DMPA for all Afghan women regardless of where they live
CHW administers DMPA injection to a FP Client
Percentage of FP Methods Provided by HPs vs. HFs in Afghanistan  
(Data source: National HMIS)
Percentage of DMPA Distributed by Health Posts vs. Health Facilities in Afghanistan

(Data source: National HMIS)
What Volunteer CHWs Do...

- Provide 63% of FP services
- Refer severely sick children and pregnant women to health facilities
- Provide iron and folic acid tablets to pregnant women
- Educate clients on healthy pregnancy and birth preparedness,
- Distribute clean delivery kits
What CHWs Do...

• Train families to use Misoprostol for prevention of postpartum hemorrhage

• Promote healthy nutrition practices, hygiene and sanitation

• Encourage community participation in the immunization of children and of women of child-bearing age

• Conduct home visits using community maps
CHWs and provision of health services

CHW and health education

CHW Provides DMPA
CBHC in Afghanistan

- Number of Active CHWs- over 22,000 (over 50% female)
- Number of health posts- more than 11,000 (one male and one female CHW/ health post)
  - Each HP covers 100-150 households on average
- Number of CHSs- over 1,000 (92% male)
  - Each CHS supervises 10-15 HPs
- Number of community shuras (committees)- over 13,000
- Number of FHA Groups- 63 (in pilot phase)
Successes

- Trained over 21,000 volunteer CHWs in all 34 provinces regarding DMPA, OCs, and condoms and supplied them with all three methods
- Increased CPR from 26% in 2006 to 42% in 2009 in 13 USAID-supported provinces
- Developed a new national policy in 2009 that permitted CHWs to provide the first dose of DMPA,
- Improved acceptance of family planning among communities
- Supported MoPH in establishment of FHA Groups in 9 provinces
Challenges

- Deterioration of security
- Shortage of female staff, especially CHSs (Only 8% of CHSs are female, yet over 50% of CHWs are women)
- Sustainability/drop out of CHWs
- Selection and training of CHWs and CHSs
- Increasing workload of CHWs
- Monitoring and supervision
- Illiteracy
What next?

- Establish effective FP Program for neglected populations - Nomads and Poor Urban
- Enhance male and religious leaders involvement
- Strengthen Literacy Programs for volunteer CHWs
- Advocate for political and donor commitment
- Train and recruit staff, mainly focusing on female health workers
What next?...

• Ensure sustainability (institutional, community/social and financial)
• Put researches into action, and implement best practices
• Improve quality of care by
• Strengthening of logistic system to ensure contraceptives security
DMPA Initiative in MALAWI
Authors: Mexon Nyirongo, Halida Akhter, Olive Mtema

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Children by Choice not Chance: DMPA Initiative in MALAWI

Malawí’s Integrated Services For FP and Prevention & Treatment of HIV/AIDS/STIs (CFPAS) Project
Malawi’s Integrated Services For FP and Prevention & Treatment of HIV/AIDS/STIs (CFPAS) Project overview

Total Population 13,931,831 (85% rural)
The average life expectancy is 46 years,
Maternal Mortality Ratio (MMR) is 984/100,000 live births.

Total Fertility Rate : 6.0,
Contraceptive Prevalence Rate : 28%, Unmet need : 28%

Malawi's AIDS prevalence hovers around 12 percent i.e. 1 in 9 adults are living with HIV. Out of 13 million, 85,000 people die annually from HIV/AIDS, 8.4 percent of young women aged 15-24 are already infected with HIV.

MDHS 2010—MMR reduce from 984-675/100,000 (2004-2009)
CPR increased from 28% to 46% in five years—3% / year
Malawi DMPA: A Model in Africa

- GOM Initiative to give DMPA at community level.
- Trained 1000 CBDAs for community support; 700,000 received FP, HIV messages
- Countries in the region learning from Malawi; AWARE II (3 West African countries visited Malawi to learn about...
Malawi’s experience in provision of injectable contraceptives at community level

- Utilizes a network of HSAs to provide injectable in hard to reach underserved rural areas
- HSAs lowest cadre of Health workers in Malawi
The Health Surveillance Assistant

- Salaried public sector full time community-based health worker under MoH.
- 12 years basic schooling + 12 weeks pre-service training

HSAs provide immunization in the community outreach where women gather to bring their children for immunization.

CFPHS - 6 day DMPA training
Policy decision on DMPA

• 2007 feasibility study
• 2008 MoH allowed HSAs to provide DMPA at community level
• 2008 consensus building Stakeholders dissemination meeting
• Developed policy and operational guidelines, training manuals, established community based DMPA logistics system
• Pilot started November 2008
USAID Supported DMPA Pilot

- Piloted in 9 districts (8MSH; 1 AHS) from Nov 2008 to Nov 2009
- Trained 30 TOTs during pilot phase
- Pre-tested training materials
- Trained 545 HSAs and 100 supervisors
- Pilot evaluated in January 2010
Community participation

- Conducted “Open Sensitization Days” with the theme “Zina Umanena – Kulera ndi anthu awiri” (“It takes two to plan a family, Let us talk about it.”)

- Included supplies, services, info.
- Counseling for family planning, HIV tests, and child immunization.
- Traditional dances, poems, dramas brings health issues to life.
Stakeholder participation

- Collaborated with community leaders, Catholic and Muslim clerics.
- In a conference on FP and HIV, Muslim leaders lauded the US govt. for supporting the project and involving community and religious leaders.
Pilot Evaluation Results

Number of Clients Accessing DMPA

Mar-09: 3,210
Jun-09: 21,238
Sep-09: 33,044
Dec-09: 29,788
Mar-10: 29,722
Jun-10: 34,503
Sep-10: 64,492
Dec-10: 65,414
Mar-11: 101,885
Comparison of Acceptor between HF and CBD Interventions

- New Acceptors Q13: HF - 17,124, CBD - 21,452
- New acceptors Q12: HF - 21,942, CBD - 18,797

Getting more users through the CBDAs than facilities.
Evaluation Results

• This CBD approach contributed to increasing access to the rural underserved communities;
• 70% of old clients switched from health facilities to HSAs
• MoH recommended DMPA scale up beyond the 9 districts
Factors contributing to success

• Strong political will in FP issues
• Accelerated efforts to reposition Family Planning
• DMPA training; pre-service
• National approach to the initiative resulted in support from other partners working in SRH in other districts (UNFPA, FPAM, BLM, CHAI)

Supportive supervision
• Erratic supply of contraceptives
• Inadequate funding for SRH commodities
• Competing priorities in the provision of health services- FP not often a priority
• Waste management at community level
• HSAs have multiple roles
• Supervision of HSAs
Lessons learnt

• Community Health worker have a significant role to play in delivery of FP and HIV/AIDS services
• By reaching the hard to reach and underserved areas use of FP methods can be greatly increased
• Working within existing government system for sustainability and use of salaried staff for community initiatives for sustainability.
• Ensure demand is matched with supply
• Ensure supportive supervision for community workers
Saving lives and improving the health of the world’s poorest and most vulnerable people by closing the gap between knowledge and action in public health.
Program Scale Up and Policy —Chicken or Egg?

The Scale up of Community-based Provision of Injectable Contraception

Dr. Angela Akol
Can program scale up occur in absence of policy?

- Expansion of best practices commonly driven by explicit policy.
- Policy facilitates knowledge dissemination, supervision and engagement of multiple stakeholders.
- Examination of CBA2I program scale up and policy enactment in Uganda.
Overview: CBA2I in Uganda
Key Outcomes

• March 2011: Amendment of *Uganda National Policy Guidelines and Service Standards for Sexual and Reproductive Health* allowing Depo Provera provision by well trained CHWs

• MOH has requested for technical assistance to develop a national scale up plan
Scale up of CBA2I in Uganda

2006
- 20 CRHWs
- 2 sites
- One district
- One partner

2010
- 260 CRHWs / VHTs
- 28 sub counties
- 7 districts
- 6 partners
- 5 country visits
- Ongoing advocacy
- Additional research
- VHT Manual
Lesson Learned:

• Expansion from 1 to 7 districts in absence of explicit policy

• Scale up to additional districts
  • Guided by pull factors - expressions of interest
  • Push factors in scale up – districts that had already begun implementation
  • Tacit approval from the MoH FPWG
Scale-up Process: Facilitating Factors and Challenges

**Facilitators**

- Compelling research evidence
- Public Health Need
- Success stories from other districts
- Advocacy

**Challenges**

- Policy
- Resources
Conclusion

• In situations of intense community need, policy action can be guided by and follow program expansion

• Explicit policy facilitates availability of funding necessary for large scale implementation