

Scaling Up Community-Based Distribution of Injectable Contraception: Case Studies from Madagascar and Uganda

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Introduction

Provision of injectable contraception by community health workers (CHWs) is a feasible, safe, and effective way to increase access to contraception for underserved populations. Efforts to expand community-based access to injectable contraception (CBA2I) are ongoing in more than a dozen countries in sub-Saharan Africa. At least half of these countries are taking measures to scale up CBA2I, which has prompted the global health community to address the growing need for systematic guidance on sustainable scale-up practices. Global guidance promotes the practice and encourages decision makers to think beyond pilot studies and demonstrations to the expansion of the practice.

The following case studies review the different steps involved in the expansion of CBA2I in Uganda and Madagascar. The demand for injectable contraception is high in these two countries, but access to family planning (FP) services is limited in the rural areas. Before initiating pilot studies, both countries had existing community-based distribution (CBD) programs but did not permit CHWs to provide injectable contraception. Despite these similarities, the two countries pursued different approaches to the expansion of CBA2I—particularly with respect to the timing of policy change. In Madagascar, a policy change triggered the process. In Uganda, a pilot study led to the gradual expansion of services, which in turn led to a formal policy change. Both approaches can lead to success.

The contrasting examples of Madagascar and Uganda can provide value lessons to implementers in other countries whose circumstances may mirror one or the other situation. The case studies are based on country reports, interviews with current and former in-country implementers, and the scale-up literature.

Use of the term “Scale Up”

The term “scale up” is used with various meanings in the reproductive health literature, and readers often bring their own assumptions to its interpretation. For this document, “scale up” refers to the geographical expansion or replication of a service into new areas of a country, which is sometimes referred to as “horizontal” scale up. Some people use the term scale up in a broader way, to include both geographical expansion as well as changes in national policies, guidelines and other health systems issues. Some refer to these systemic changes as “vertical” scale up. This document treats “policy change” separately from scale up, to identify the key steps involved in these two case studies.

Madagascar: Policy Change Precedes Scale Up



Policy Change

In 2006, when Madagascar’s Ministry of Health of Family Planning and Social Protection (MOHFPSP) was set to update the *National Reproductive Health Norms and Procedures*, the country was ripe for policy change on the community-based distribution of injectable contraception (CBDI). For more than a decade, volunteer CHWs¹ supported by the MOHFPSP and non-governmental organizations (NGOs) had been distributing oral contraceptive pills and condoms. Yet, injectable contraception was not part of the methods CHWs could provide. Family Planning was central to the government of Madagascar’s health agenda,¹ which recognized that increasing the contraceptive prevalence rate (CPR) would help to decrease maternal mortality, unintended pregnancies and abortion rates, while improving the health of women and children throughout Madagascar.² Moreover, the health policy environment promoted innovation to improve health outcomes.² At the time, CBDI was new to sub-Saharan Africa; a successful pilot, which had just been completed in Uganda, showed that the practice was safe and feasible. The result reinforced previous evidence and programmatic experiences from Latin America and Asia.

In 2006, Madagascar became the first country in sub-Saharan Africa to formally amend its policy—allowing CHWs to provide injectable contraception. Policy-makers recognized that the provision of injectable contraception—DMPA, otherwise known by its brand name, Depo Provera—by CHWs at the community level was an effective, evidence-based strategy to improve access to FP among underserved populations. The policy was enacted with the understanding that pilot testing would be conducted to assure the safety, feasibility and effectiveness of this approach within Madagascar.

Pilot Study

Two national managers from the MOHFPSP were appointed to serve as co-investigators on the pilot study, and a national steering committee led by the MOHFPSP held regional coordination meetings. Two regions—Anosy and Alaotra Mangoro—representing diverse geographic, social and cultural norms, were chosen for the pilot. Results from the pilot study confirmed that the provision of DMPA by CHWs was safe, feasible and acceptable. The CHWs demonstrated their competence in providing injections, counseling their clients and managing their clients’ re-injection schedule. The pilot study also showed that CBDI appeared to increase contraceptive use. Additionally, CHWs and supervisors indicated that the project should continue, and nearly all the clients who were interviewed said that they would return to the CHW for reinjection and would recommend the service to a friend.³

The pilot study also generated suggestions to improve the program. The CHWs recommended a longer training program and streamlined reporting tools to facilitate better recordkeeping. The health center staff did not supervise CHWs as often as planned because of their heavy workloads, so investigators recommended an increased reliance on NGO-appointed supervisors during the scale up. Lastly, stockouts were a challenge for the CHWs because of the long distances they had to travel to acquire supplies. Improved commodity management, particularly during rainy seasons when travel is prohibitive, was recommended to address this challenge.³

¹ The term community health worker (CHW) will be used for this document, however in Madagascar they are referred to as *agents de santé communautaire (ASC)*.

Scale Up

In December 2007, the *Reunion de Coordination Nationale des Activites Sante de la Reproduction/Planification Familiale* (National Coordination Meeting for Reproductive Health and Family Planning) laid the groundwork for launching the expansion of CBI. The meeting organizers disseminated results from the pilot study to MOHFSP officials (from all parts of Madagascar) and they informally assessed potential interest in the project among district health inspectors who were in attendance. Results and recommendations from the pilot were presented by the MOHFSP project investigator and the district medical inspector to the MOHFSP and to district health inspectors.¹ In addition, two CHWs who had participated in the pilot study shared their experiences with the country's regional medical directors, and this generated more enthusiasm for the project. In addition, country staff from the pilot project and MOHFSP officials informally surveyed the districts to determine which district officials were most supportive of CBI for the initial roll out.

Scale up began by providing support for CBI in communities where there was the most enthusiasm and the strongest CBI infrastructure to support the project. Interested districts requested support from the MOHFSP. FHI demonstrated its commitment to the project, which provided a strong start for the national rollout. This was an important step because some local health professionals resisted this new way of providing injectables, and they needed to witness the success of other expansions to be persuaded. This strategy also helped to ensure support for the project from the community and it helped to generate interest in other communities.¹

By April 2009, the MOHFSP and FHI were collaborating with 16 NGOs to scale up the pilot study in another 25 districts, though many more communities were eager to start the program.⁴ A total of 385 agents provided DMPA services to 111 communes across 27 districts. To address the recommendations that came out of the pilot, the trainings were lengthened from 3 days to 3½ days. In addition, the programs were more strongly linked to the public sector, and integrated into all levels of the government as well as the community health systems and leadership structures. Extension workers from the NGOs became the primary supervisory agents because the clinic-based staff lacked the time.¹

A protracted political crisis, beginning in early 2009, hindered cooperation between the government, the NGOs and the health centers. The crisis interrupted supply chains, halted communication between the Ministry of Health (MOH) and the implementing agencies, and disrupted the supervision and monitoring of programs. Although the number of CHWs increased after the crises because of increased training, needed commodities are still in short supply.

Lessons Learned

In Madagascar, the favorable political environment greatly facilitated the rapid implementation and scale up of CBI. A few key lessons emerge from the scale up in Madagascar:

- The expansion into districts that were eager to implement CBI propagated enthusiasm in other districts as they witnessed the successes and heard positive experiences from district and community leaders. The national dissemination meeting—at which district health officials, health clinic staff, and CHWs spoke about their experiences with the project—was particularly useful for building support among key stakeholders.¹
- Strong relationships between the district officials, NGOs, health providers, and the CHWs were extremely important for effective collaboration on the project. Stakeholders had to collaborate

for the trainings, supervision, monitoring, referrals, and for supply logistics in order to adapt to any changes and to maintain the quality of the services.²

- The involvement of community leaders from the beginning of the program was essential for fostering community ownership of the CBDI. For example, community leaders participated in the selection of the CHWs, and made speeches in the marketplace during the ceremonies that introduced the CHWs to the community. Women's groups tapped into the communication networks in the community and so helped to disseminate information about the CBDI program.²

Uganda: Scale up Precedes Policy Change



In contrast to the scale up process in Madagascar, Uganda implemented a phased expansion process following a 2004-2005 pilot study. Although Uganda's MOH informally supported this scale-up process, the MOH did not make a formal policy change until 2011. As requested by the public sector, efforts towards this policy change occurred simultaneously with a phased scale up of the pilot study and an expansion into the public sector. The goal of the scale up was to collect experiences from the expanded implementation while supporting efforts for policy change.⁵

Pilot Study

Although Uganda's national health policies supported FP, the CHW cadre was not permitted to administer injectables at the time of the pilot study.⁵ Instead, permission to test the intervention was granted by the MOH. A champion within the MOH was eager to test innovative ways of improving reproductive health, and with his support, Uganda became the first country in sub-Saharan Africa to pilot CBDI, collaborating with FHI and Save the Children (SC) in the Nakasongola district.

Evidence from the pilot study demonstrated that (1) CHWs safely provided DMPA services, (2) clients were satisfied with their services, and (3) there was no significant difference between the CHWs and the clinics in the number of second injections that were provided.⁶ Based on the evidence from the initial pilot study, SC expanded the project to two additional districts (Luwero and Nakaseke), and generated similarly positive results.

Scale Up

In addition to expanding CBDI to more districts, the MOH requested that FHI test the pilot in the public sector to determine the sustainability of the project. This was particularly relevant because the MOH had developed their Village Health Team strategy, which standardized the community-based approach to providing health services in Uganda, and provided a potential structure for national scale up of CBDI in the public sector.⁵

Throughout the pilot and the scale up, advocacy efforts increased the visibility of the project and disseminated information to health professionals, policy makers, district officials and community leaders. In addition to the national-level champion within the MOH, district-level champions were identified and provided with support for the use of radio broadcasts and community meetings to

disseminate locally tailored messages about the importance of FP and the use of CHWs to improve access to these services. As the project prepared for testing in the public sector, advocacy materials were disseminated by the MOH to all districts in Uganda. The materials included evidence that supported the scale up as well as offers of limited technical support to local health officials who wanted to replicate the project in their districts.⁷

As a result of advocacy efforts, seven districts requested technical support to implement CBDI. The MOH selected Busia and Bugiri districts for public sector testing in eastern Uganda because they had existing and active CBD of FP programs, had demonstrated commitment at the program management and community levels, and had a high unmet need for FP in the community. Additional considerations were the order of request received and the availability of funds for technical assistance.⁷ A rapid assessment tool was used to evaluate the need for the services and the communities' capacity to add the provision of DMPA to the CBD services. The assessment revealed that the CBD programming had weakened in the previous year because of funding constraints, which reduced the number of active CHWs and service activities, such as supportive supervision.⁷ However, district officials were committed to addressing the unmet need for FP, so they agreed to allocate more funding and staff time to support the management, supervision and the monitoring and evaluation of the program.⁷

There were a few differences between the implementation strategy for the pilot projects, and the testing of CBD of DMPA in the public sector. For example, as the technical partner, FHI provided guidance to district core teams—composed of district health officers, clinic managers, clinic midwives, and health assistants—to support them in managing all operational activities related to scale up rather than directly implementing these activities as it had done in the pilot projects.⁷ Technical assistance involved support for training, materials, job aids, program management, the development of a strategy for monitoring and evaluation, and the analysis of CHW service data that had been collected by the supervisors.⁷ In addition, district core teams led consensus-building meetings with political and civil-society leaders who could influence decision making.⁷

To promote integration with public-sector systems, the monitoring and the evaluation of the public sector programs were integrated into the existing supervisory structure of the district health office. Clinic-based midwives at the healthy facility conducted monthly supervisions, whereas NGO extension workers had supervised the pilot projects. In addition, NGO extension workers had delivered supplies directly to the CHWs during the pilot, whereas CHWs obtained supplies from the health centers in their service areas during the public-sector testing.⁷ Additional district-level contributions included free commodities (which they had been providing before CBDI was introduced), general FP training, and demand-generating activities within the communities.⁷

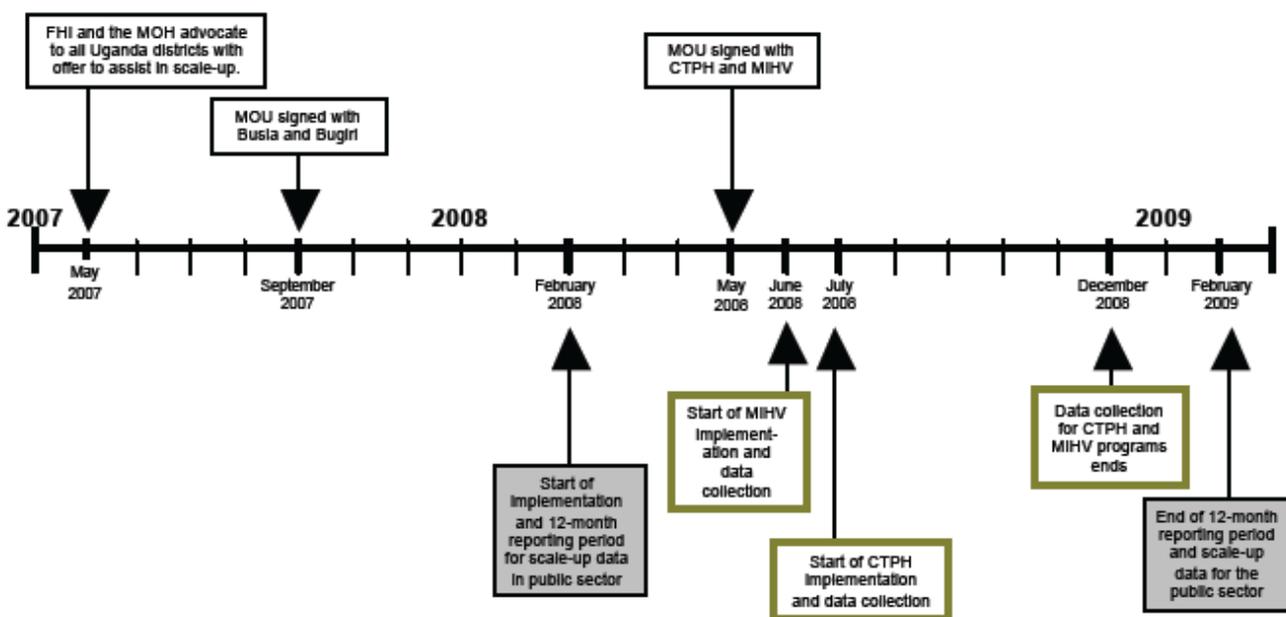
It was a challenge to add DMPA to existing CBD programs (that had limited external inputs) and to integrate the project into existing health systems. For example, the districts could not afford to reimburse CHWs for their travel to monthly supervisory meetings at the health center; so, many CHWs did not attend these meetings. In response, CHWs in Busia designated a “CHW leader” who provided regular support and leadership to other CHWs—an approach that was adopted by other CBD programs in the country.⁷

Stock outs were an additional challenge. Although the USAID | DELIVER Project had directed logistics-management trainings for district-core teams, health-facility staff, and CHWs,⁷ stock outs were still occurring because commodities could not be acquired. Health centers adapted by borrowing commodities from each other and from other districts.⁷

During the public-sector testing in Busia and Bugiri, CBDI was being scaled up in two other districts (Kanungu and Mubende) by two NGOs, Conservation Through Public Health (CTPH) and Minnesota International Health Volunteers (MIHV), respectively. The implementation process was similar to the pilot project. A recent publication provides more details and lessons learned.⁸

Policy Change

In March 2011, the MOH announced new guidelines that enabled CHWs to provide injectable contraception. The process of changing the country's policy took six years after results from the initial pilot project were documented—far longer than the process took in Madagascar. During this time, however, scale-up activities increased access to DMPA for women in remote communities and provided further evidence to encourage the MOH to change its policy.



Source: Krueger K, Akol A, Wamala P, Brunie A. Scaling up community provision of injectables through the public sector in Uganda. *Stud Fam Plann.* 2011 Jun;42(2):117-24.

Lessons Learned

A few key lessons emerge from the scale-up process in Uganda:

- Engaging the MOH from the beginning promoted country ownership and opened communication lines for ongoing dialogue about the project.⁵
- Community- and district-level engagement is essential for the implementation of a strong CBDI program.
- A sustainable program requires the integration of CBDI with existing systems in the public sector. However, existing systems may need improvement; development partners and public-sector agencies must determine whether they have the financial and technical support to fully implement a CBDI program.⁷

- In response to the challenges that arise from the implementation of CBDI, communities have developed innovative solutions that are proving to be valuable to other implementers.⁷

Conclusions

The path to scale up and policy change depends on the local context. Scale-up efforts greatly expanded access to DMPA for remote populations in Uganda and Madagascar, regardless of whether policy change preceded this process. Policy change may have accelerated the expansion efforts in Madagascar, but it was not a precondition for scale up in Uganda. In countries where the policy change involves a lengthy process, the continued expansion of CBA2I provides a greater number of communities with these services while also contributing to the body of global evidence for the practice.

The scale up of CBDI continues in both countries, which also continue to face some common challenges. The sustainability of CBDI demands that further actions be taken to integrate CBDI into the existing health systems. Unfortunately, these systems are under-resourced in staff, management and funding. Although innovative solutions can address some of the challenges, additional strategies are needed.

Common lessons can be learned from the scale-up experiences of Uganda and Madagascar:

- I. **The continuous engagement of the MOH is necessary for successful scale up.** In Uganda, an ongoing dialogue between the MOH and project managers helped to identify the evidence that was needed to change the country's policy and permit testing in the public sector. Both countries included MOH officials as investigators on the pilot, which instilled a sense of ownership from the beginning.
- II. **Involving stakeholders in the implementation process is effective in creating champions.** Study tours allowed government officials, community leaders, and health professionals to witness the benefits of expanding CBA2I. Continued, wide-spread dissemination of results through informal interactions, study tours and national meetings built the momentum needed to continue scale up.
- III. **Scale-up efforts that are integrated into existing community, leadership and logistics systems promote sustainability and community ownership.** Village leaders and district officials were involved in the selection of CHWs, the training, and in community engagement. Monitoring, supervision and waste management was integrated into the existing structures to the greatest extent possible. These actions increased the sustainability of the projects, and promoted community ownership.

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