

Community Health Worker Provision of Injectable Contraceptives: An Effective CBA2I Strategy

First Lady of Zambia Supports CBA2I

Zambia is struggling with a human resource crisis. We have piloted a study on community workers providing injectable contraceptives and the results were very promising. We need to move from the pilot to scale up, and we've made commitments to do this.

– Dr. Christine Kaseba-Sata
First Lady of Zambia
at the Women Deliver
Conference, May 2013

Introduction

Countries around the world have demonstrated that allowing trained community health workers¹ (CHWs) to administer injectable contraceptives (injectables) can expand access to a woman's preferred contraceptive method, reduce unmet need for family planning in underserved areas, and address the critical health workforce shortage in many countries. In addition, community-based family planning (CBFP) programs that add injectables to the list of contraceptives available can increase the contraceptive prevalence rate. In Kenya for example, adding community-based provision of injectable contraceptives to the method mix dramatically increased contraceptive uptake and improved method choice during their pilot program.²

Because community-based access to injectable contraceptives (CBA2I) has the potential to significantly expand access to and use of modern contraceptive methods, several countries are employing CBA2I strategies to help achieve their FP2020 goals.

This set of resources and DVD promote CHW provision of injectable contraceptives through new and existing CBFP programs.

Audience

These resources are intended to be used by advocates, program managers, policymakers, donors, ministry of health staff, and other key stakeholders such as faith-based groups, media, and family planning champions who are interested in expanding CBA2I through CHWs in countries where they work.

How to Use the Advocates Package

Use these resources to craft a strategy for building support for CBA2I among key decision makers in your country. Begin by reviewing Resources 1–6. Then use the suggestions in *Key Actions for CBA2I Advocacy* (Resource 7) to develop an advocacy action plan.

You may use the resources in this package and those in the Knowledge for Health (K4Health) CBA2I Toolkit to develop talking points and custom-designed advocacy materials to share with stakeholders who support your advocacy objectives. www.k4health.org/toolkits/cba2i.

Use the Advocates Package to Achieve FP2020 Goals

The Family Planning 2020 (FP2020) goal of reaching 120 million new users of family planning by 2020 can only be achieved if contraceptive services are extended beyond the facility and into communities,

¹ The terms "community health worker" and "CHW" as used in these resources refer to lay health workers who provide family planning commodities and services. Lay health workers are community-based health workers who have received training but often do not have formal professional or paraprofessional education or certificates. Other terms for these health workers include community reproductive health agents, community health officers, village health workers, and community-based distributors of family planning.

² Kenya Ministry of Public Health and Sanitation (MOPHS)—Division of Reproductive Health, FHI 360, Jhpiego, USAID/APHIA II Eastern, Tharaka District Health Management Team. 2010. *Introducing Community-Based Distribution (CBD) of Injectable Contraceptives: Experiences and outcomes from a pilot project in Tharaka District, Eastern Province of Kenya*. Tharaka, Kenya: MOPHS. Available at: <http://www.k4health.org/toolkits/cba2i/introducing-community-based-distribution-cbd-injectable-contraceptives-experiences>

PACKAGE RESOURCES

1. Provision of Injectable Contraceptives by Community Health Workers
2. Initiation and Continuation of Injectable Contraceptives by Community Health Workers
3. Community-Based Access to Injectable Contraception: *Radical Common Sense* (advocacy video)
4. WHO *Optimize MNH* Guidance: Recommendations on CHW Provision of Injectable Contraceptives (2012)
5. Conclusions from the WHO Technical Consultation on Expanding Access to Injectable Contraception (2009)
6. Guide to Resources in the Online CBA2I Toolkit
7. Key Actions for CBA2I Advocacy

reaching the millions of women and couples whom health system fails to reach effectively. There is a significant history of improving access to family planning through community-based services, as demonstrated in countries such as Bangladesh, Ethiopia, Indonesia, Kenya, and Malawi. For example, in a pilot project in Kenya in 2009, the percentage of women using a modern contraceptive method tripled in the targeted area when CHWs began offering injectables.³ Expanding this model of community-based family planning can reach more women and couples, increase the available contraceptive options, improve continuation of contraceptive methods, and increase the number of new family planning users, thus helping to meet the goals of FP2020.

Other CBA2I Approaches

Besides **CHW provision of injectable contraceptives**, other strategies for expanding community access to injectable contraceptives in rural and hard-to-reach areas include use of **drug shops and mobile service delivery**.

- **Drug Shops**



Photo: 2012 Akintunde Akinleye/NURHI, Courtesy of Photoshare

Drug shops are small commercial shops that are legally allowed to sell nonprescription drugs and prepackaged medicines. Drug shops are also known in various countries as licensed chemical shops, patent medicine shops, and accredited drug dispensing outlets. They are often the first line of health care in poor countries, especially in rural areas that have few private or public clinics. Many drug shops sell family planning methods over the counter (condoms and oral contraceptives), and some provide injectable contraceptives even though they may not be licensed to do so. Drug shops are already popular sources for health care advice, medicines, and supplies, and could offer opportunities to reach existing and new family planning clients. For more information about how to promote family planning through drug shops, see

the K4Health Community-Based Family Planning Toolkit and the Advancing Partners & Communities (APC) brief, *Provision of Family Planning within Drug Shops: A Promising Approach to Increasing Access*.

- **Mobile Service Delivery**

Mobile service delivery, or mobile outreach, is the provision of family planning services by a mobile team of trained providers. Mobile services offer family planning methods to underserved communities by bringing equipment and supplies that are not available locally. The teams visit and provide services at lower-level health facilities or other community facilities such as schools and health posts. Mobile service team members

partner with local CHWs, who promote the services in advance to build demand and assist teams with service provision as needed. For more information, see the K4Health Community-Based Family Planning Toolkit, <https://www.k4health.org/toolkits/communitybasedfp>.



Photo: 2012 Akintunde Akinleye/NURHI, Courtesy of Photoshare



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³ Ibid.

Provision of Injectable Contraceptives by Community Health Workers

1

Description: Summarizes the global status of provision of injectable contraceptives by trained community health workers (CHWs) and provides evidence and program examples that demonstrate the feasibility and benefits of this service delivery model.

Status of Community-Based Access to Injectables

As of March 2014, 14 countries in sub-Saharan Africa (see list at right) are supporting community-based access to injectables (CBA2I) by implementing CHW provision of injectable contraceptives pilots, scaling up and nationalizing these programs, and advocating policy change. Community health workers provide injectable contraceptives in other parts of the world as well, including Afghanistan, Bangladesh, Bolivia, Guatemala, Pakistan, and Peru. For more information about the expansion of CBA2I in sub-Saharan Africa, see the map in the Knowledge for Health CBA2I Toolkit.

Evidence from Groundbreaking Pilots

Uganda (2003–2005)

From 2003 to 2005, the Uganda Ministry of Health (MOH), FHI 360, and Save the Children/USA conducted a pilot study¹ among 20 CHWs in a Save the Children community-based reproductive health program in Nakasongola District. This study was the first rigorous evaluation of the provision of injectable contraception by lay health workers in Africa; it compared the quality of care provided by CHWs to that provided by nurses and midwives in clinics.

The district health educator trained CHWs to provide depot-medroxyprogesterone acetate (DMPA), a common injectable contraceptive, with auto-disable (single-use) syringes. From March to November 2004, 945 clients received DMPA (562 from CHWs; 383 from nurses and midwives in 10 health clinics). Study results showed that the CHWs competently counseled clients and provided DMPA, achieving continuation rates and client satisfaction comparable to that of clinic-based DMPA provision.

CBA2I BY CHWs IN SUB-SAHARAN AFRICA

- Ethiopia
- Guinea
- Kenya
- Liberia
- Madagascar
- Malawi
- Mali
- Nigeria
- Rwanda
- Senegal
- Sierra Leone
- Togo
- Uganda
- Zambia

*CBA2I Country Status
as of March 2014*

¹ Stanback, J., A.K. Mbonyeb, and M. Bekiita. 2007. "Contraceptive injections by community health workers in Uganda: a nonrandomized community trial." *Bulletin of the World Health Organization* 85:768–773.

After the pilot, the Uganda MOH authorized Save the Children/USA to expand the practice to six additional districts where poor access to clinical services limited family planning use. In 2008, the MOH scaled up CHW provision of FP, including injectable contraceptives, to the public sector in Bugiri and Busia districts in conjunction with the national roll-out of Uganda's Village Health Team (VHT) strategy. In 2011, the MOH signed into policy an addendum to Uganda's national reproductive health guidelines that permits trained CHWs to provide injectable contraceptives.

Madagascar (2006)



Photo: Yosef Hadar/World Bank

In 2006, the Madagascar Ministry of Health and Family Planning (MOHFP) revised national guidelines to include injectable contraceptives among the methods that CHWs could provide. Before applying the new policy, the MOHFP wanted to test its feasibility. In 2007, the MOHFP joined implementing partners in a pilot study to determine whether community-based provision of DMPA could be successfully integrated into existing programs.^{2,3} This pilot was the first public-sector CHW program to provide injectable contraceptives in Africa. Study staff trained 61 experienced CHWs from 13 remote communities. After six months of service provision, an evaluation team reviewed service records and conducted interviews with CHWs, their supervisors, and clients. The CHWs provided DMPA injections to 1,662 women; 41% were

new FP users or restarting contraception, and 28% had never used contraception. The CHWs demonstrated competence in injection technique, counseling, and managing their clients' reinjection schedules. The service appeared to increase contraceptive use, and nearly all clients interviewed said they would return to the CHW for reinjections and would recommend the service to a friend. After the pilot, the MOHFP scaled up the program to 24 additional districts.

Other CBA2I Program Highlights

Kenya

- **Pilot 2009–2010:** The Kenya MOH trained 31 CHWs in Thakara District to provide DMPA in addition to the pills and condoms they were already providing. The CHWs gave 2,453 injections during the pilot period, with no needlesticks or injection site infections reported. The 12-month continuation rate was 68%, and about three-quarters of DMPA clients who had previously received DMPA from a clinic opted to switch to CHWs. The pilot concluded that CHW provision of DMPA in Kenya was safe, acceptable, and feasible.⁴
- **Policy change 2012:** In November 2012, the Kenya MOH issued an official policy statement allowing provision of DMPA by trained CHWs in hard-to-reach areas.

² Hoke, T., S. Wheeler, K. Lynd, et al. 2011. "Community-based provision of injectable contraceptives in Madagascar: 'task shifting' to expand access to injectable contraceptives." *Health Policy and Planning* 2011;1-8.

³ Hoke, T.H., and S.B. Wheeler. 2008. *Safety, Feasibility, and Acceptability of Community-based Distribution (CBD) of Depot Medroxy Progesterone Acetate (DMPA) in Madagascar*. Durham, NC: FHI 360.

⁴ Kenya Ministry of Public Health and Sanitation - Division of Reproductive Health, FHI 360, Jhpiego, USAID/APHIA II Eastern, Thakara District Health Management Team. 2010. *Introducing Community-Based Distribution (CBD) of Injectable Contraceptives: Experiences and Outcomes from a Pilot Project in Thakara District, Eastern Province of Kenya*. Thakara, Kenya: MOPHS. Available at: <http://www.k4health.org/toolkits/cba2i/introducing-community-based-distribution-cbd-injectable-contraceptives-experiences>.

- **Scale-up 2012–present:** The Nursing Council of Kenya recommended scale-up to 10 counties or sites, emphasizing standardized training, regulations, and supervision.

Senegal

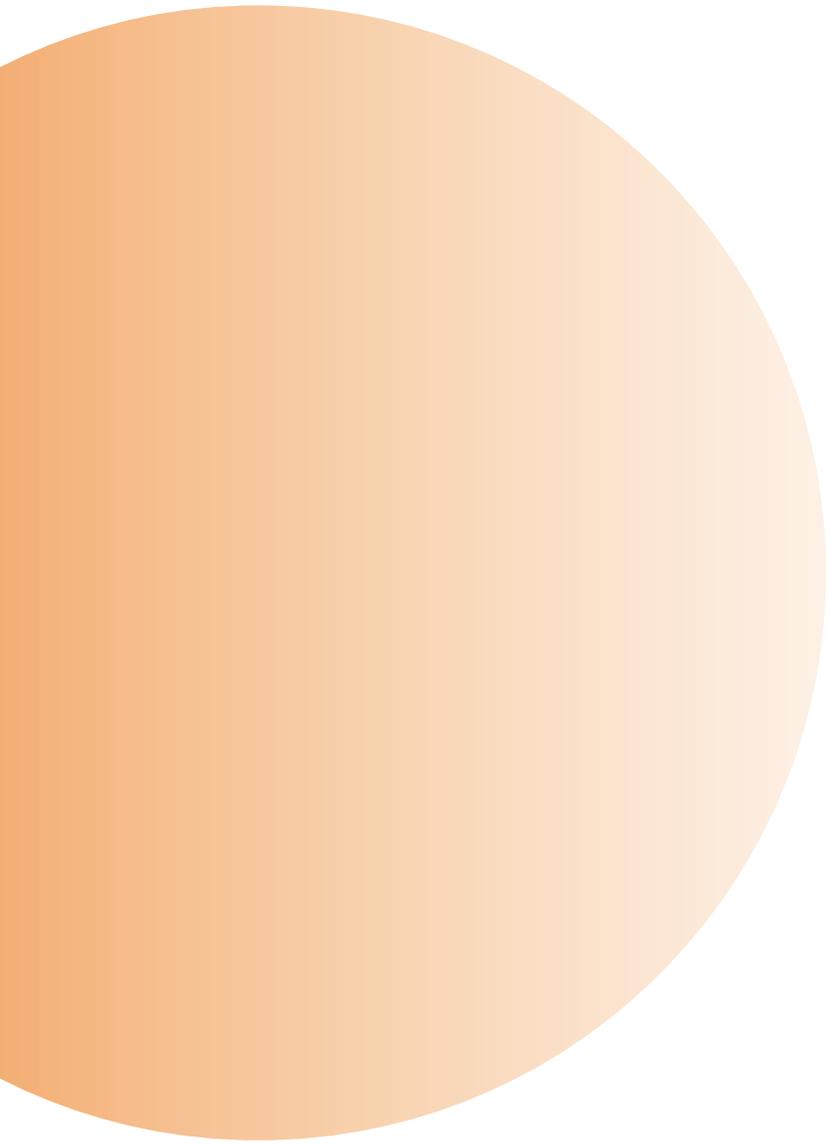
- **Policy change 2010:** Based on the positive results of a 2010 pilot of community-based distribution (CBD) of pills, the Ministère de la Santé et de l'Action Sociale (MOH) revised the national reproductive health policy, norms, and standards document to allow two cadres of CHWs, *agents de santé communautaire* and *matrones*, to administer pills and injectable contraceptives.
- **Pilot 2012–2013:** The MOH implemented a CBA2I demonstration pilot in 2012. During the pilot, 45 CHWs served 1,078 family planning clients; 670 chose DMPA, and of these, 65% were first-time users of contraception. Most CHWs correctly and confidently provided DMPA injections and counseling. Clients were satisfied with the services (99%) and overwhelmingly (94%) stated their intent to get their next injection from CHWs. This pilot demonstrated the feasibility of CBA2I in Senegal.
- **Scale-up 2013–present:** In May 2013, pilot results were shared and discussed with key stakeholders, who endorsed scaling up the service and made several recommendations to facilitate the process.

Nigeria

- **Pilot 2009–2010:** A pilot project in Gombe, a predominately Muslim state, demonstrated that client uptake of injectables is higher when they are provided at the community level as compared to facility provision, and showed that senior community health extension workers (CHEWs) can safely administer injections and dispose of waste.
- **Policy change 2012:** The National Council on Health approved a recommendation from the Federal Minister of Health that allows CHEWs to provide injectable contraception and encourages the Nigeria state Ministries of Health to scale up this practice.

Summary

Given the popularity of and preference for injectable contraceptives in sub-Saharan Africa, the widespread success of the CHW model for CBA2I is a key step in reducing unmet family planning needs across Africa and in other regions of the world.³



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Initiation and Continuation of Injectable Contraceptives by Community Health Workers

2

Description: Summarizes the evidence on community health worker (CHW) provision of injectable contraceptives in sub-Saharan Africa that validates the feasibility and safety of CHW initiation and continuation of injectable contraceptives.

Injectable contraceptives are the most popular family planning method in sub-Saharan Africa.¹ When governments allow CHWs to initiate this method away from a facility, they remove a major medical barrier for women in hard-to-reach areas who want to access family planning services. The World Health Organization (WHO) recommends that CHWs screen, initiate, and reinject clients who choose injectable contraceptives.

WHO Recommendations

The latest WHO task-sharing² recommendations state that trained CHWs can, with targeted monitoring and evaluation, initiate and reinject injectable contraceptives using a standard syringe.³

Evidence from the Literature

Initiation

- “The results of this review provide consistent evidence that appropriately trained CHWs can screen depot-medroxyprogesterone acetate (DMPA) [an injectable contraceptive] clients effectively, provide injections safely and counsel on side effects appropriately. Clients of CHWs receiving DMPA had outcomes equivalent to those of clients of clinic-based providers of progestin-only injectables.⁴ Clients are satisfied with community-based provision of DMPA, and trained CHWs are comfortable in their ability to provide DMPA. The data also show that provision of DMPA by CHWs expands choice for underserved populations and indicate that community-based services lead to increased uptake of family planning, especially under conditions of low contraceptive prevalence, high unmet need, poor access to a range of methods and limited access to clinic-based services.”

—Malacher, S., O. Meirik, E. Lebetkin, et al. 2011. “Provision of DMPA by community health workers: what the evidence shows.” *Contraception* 83(6):495-503.

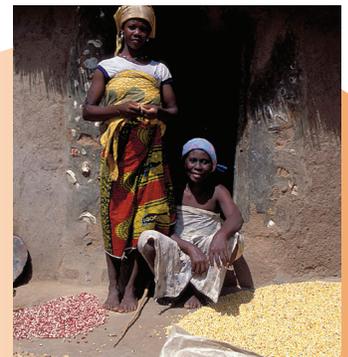


Photo: Curt Carnemark/World Bank

¹ United Nations, Department of Economic and Social Affairs, Population Division. *World Contraceptive Use 2011*. New York: United Nations. Available at: http://www.un.org/esa/population/publications/contraceptive2011/wallchart_front.pdf.

² See Resource 4 for a detailed description.

³ World Health Organization (WHO). 2012. *WHO Recommendations: Optimizing Health Worker Roles to Improve Access to Key Maternal and Newborn Health Interventions through Task Shifting*. Geneva: WHO. Available at: <http://www.optimizemnh.org/>.

⁴ The most common progestin-only injectables are Depo-Provera, (depot-medroxyprogesterone acetate, or DMPA) and Noristerat (norethisterone enantate). This category does not include combined injectables, which contain progestin and estrogen.

- “Of the 2,453 injections provided by the CHWs, no cases of injection site infection or needle sticks were reported—an indication that the CHWs provided the services safely.”
—Olawo, A.A., I. Bashir, M. Solomon, et al. 2013. “A cup of tea with our CBD agent ... ’: community provision of injectable contraceptives in Kenya is safe and feasible.” *Global Health Science and Practice* 1(3):308-315.
- “Operational guidelines should reflect that appropriately trained CHWs can safely initiate use of DMPA and provide reinjections.”
—Stanback, J., J. Spieler, S. Iqbal, et al. 2010. “Community-based health workers can safely and effectively administer injectable contraceptives: Conclusions from a technical consultation.” *Contraception* 81(3):181.
- “Among the CRHW [community-based reproductive health worker] clients, 56% received their first injection in the home of their CRHW, 35% received the injection in their own home, 5% went to the clinic and 4% received their injection in another location (some CRHWs reported meeting with clients in the home of mutual friends or in the bush).”
—Stanback, J., A.K. Mbonyeb, and M. Bekiita. 2007. “Contraceptive injections by community health workers in Uganda: a nonrandomized community trial.” *Bulletin of the World Health Organization* 85:768–773.

Continuation

- “The 12-month continuation rate of 68% (measured by acceptance of a fourth injection at 9 months) seen in the study compares favorably with other studies of DMPA continuation. This reflects well on the ability and performance of CHWs as well as client satisfaction with the method and services. Since the CHWs were based in the community, they were able to follow up with the clients who forgot their re-injection dates, thus helping to enhance DMPA continuation.”
—Olawo, A.A., I. Bashir, M. Solomon, et al. 2013. “A cup of tea with our CBD agent ... ’: community provision of injectable contraceptives in Kenya is safe and feasible.” *Global Health Science and Practice* 1(3):308-315.
- “In both follow-up surveys CBRHA [community-based reproductive health agent] clients were overwhelmingly in favour of receiving their injections at home or in the home of the CBRHA.”
—Prata, N., A. Gessesew, A. Cartwright, et al. 2011. “Provision of injectable contraceptives in Ethiopia through community-based reproductive health agents.” *Bulletin of the World Health Organization* 89(8):556-564.
- “When non-continuers [among CRHW clients and clinic clients] were asked why they did not receive a second injection, it was notable that clinic clients were nearly twice as likely as CRHW clients to report dissatisfaction with the method (40% versus 22%), and 10 times as likely to report that they had forgotten to continue (20% versus 2%).”
—Stanback, J., A.K. Mbonyeb, and M. Bekiita. 2007. “Contraceptive injections by community health workers in Uganda: a nonrandomized community trial.” *Bulletin of the World Health Organization* 85:768–773.



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Community-Based Access to Injectable Contraception: *Radical Common Sense*

3

Description: Describes a short advocacy video that can be used to promote community-based access to injectable contraceptives (CBA2I) through community-based family planning programs.

This seven-minute advocacy video presents research and programmatic evidence on the provision of injectable contraceptives by community health workers (CHWs) and describes efforts to implement CHW provision of injectable contraceptive programs throughout sub-Saharan Africa. The video tells a compelling story of a Ugandan woman who has benefited from the family planning services offered in her community.

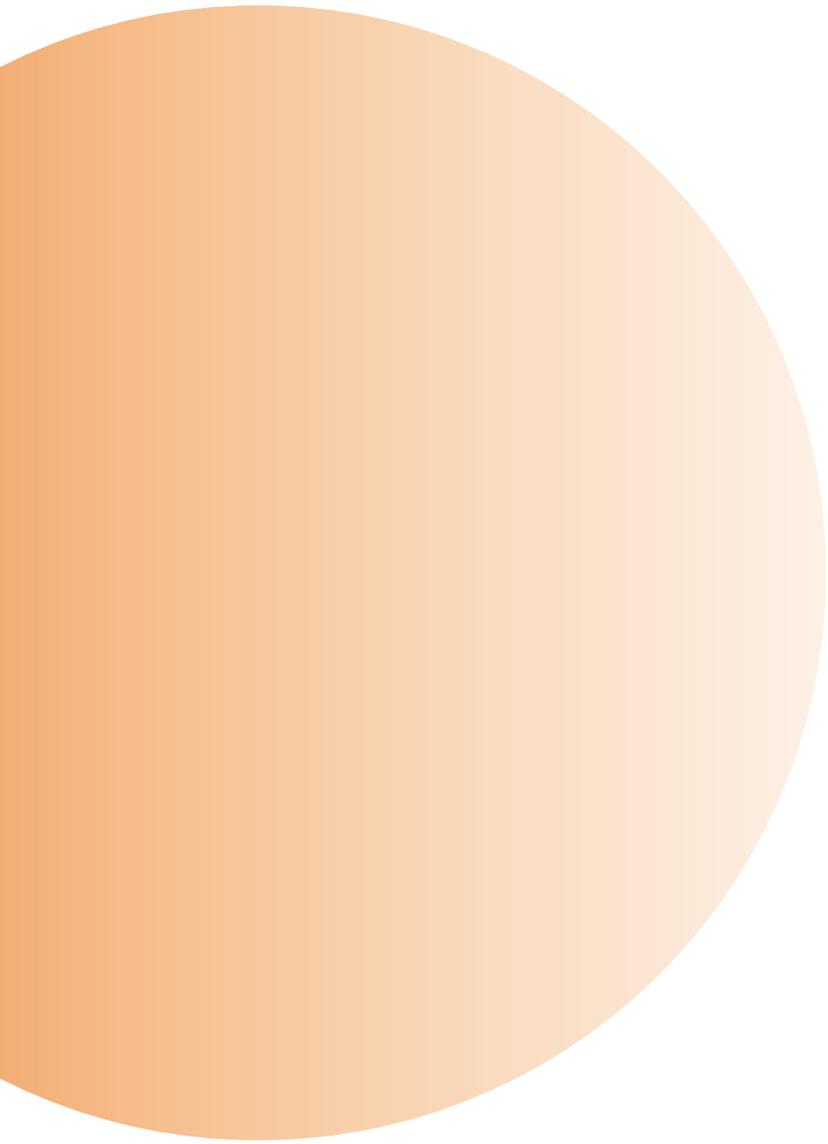
This video can be shown to stakeholders and posted on social media outlets with the goal of engaging viewers across community, district, regional, and national levels in conversations about CHW provision of injectable contraceptives. This video was shown and distributed at the 2011 International Conference on Family Planning in Senegal, the Second Global Symposium on Health Systems Research in Beijing (2012), and at the 2013 Francophone West Africa Community-Based Family Planning Partners Meeting in Senegal.

This video is available in French and English in the Knowledge for Health CBA2I Toolkit. It is located under the **Advocate** tab. <http://bit.ly/1nK4XtR>



CONTACT INFORMATION

For additional copies of the DVD, please contact:
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WHO Optimize MNH Guidance: Recommendations on CHW Provision of Injectable Contraceptives (2012)

4

Description: Describes the latest World Health Organization (WHO) task-sharing recommendations related to initiation and reinjection of injectable contraceptives by community health workers (CHWs) and confirms the high-level support for CHW provision of injectables.

Task-Sharing Definition

Task-sharing, sometimes known as task-shifting, is the distribution of tasks and responsibilities among cadres of health workers to increase access to and use of health care services and to improve cost-effectiveness within health systems. Task-sharing involves training mid- and low-level cadres of health workers—such as clinical officers, auxiliary nurses, and CHWs—to deliver some services offered by higher-level cadres in order to optimize the reach of a limited health workforce.

WHO Recommendations: Optimizing Health Worker Roles for Maternal and Newborn Health *Optimize MNH* Guidance

In 2012, WHO convened panels of international experts to review and recommend strategies for task-sharing to improve maternal and newborn health (MNH). Development of the *Optimize MNH* guidance followed a formal, structured process involving a thorough review of available evidence and the participation of more than 60 technical and programmatic experts from 23 countries. The resulting guidance includes a set of recommendations to increase access to modern methods of family planning and improve family planning services.^{1,2}

On the question of whether CHWs should initiate and reinject injectable contraceptives using a standard syringe, the WHO concluded:

- “[B]ased on program experience, we concluded that the intervention has the potential to improve equity by increasing access to family planning, and does not appear to have associated safety issues. In many settings, lay health workers [CHWs] already deliver some form of contraceptive counseling and use injections for other conditions. We therefore suggest that this option be considered in the context of targeted monitoring and evaluation. We suggest that this intervention be implemented where a well-functioning CHW program already exists.”²

This high-level support for the provision of injectable contraceptives by CHWs is essential to advocates’ efforts to implement supportive CBA2I policy and programmatic recommendations.

TASK-SHARING BENEFITS

Family planning needs a lot of talking to clients and yet I am always busy with deliveries, antenatal, immunization, and many other tasks. The lay health workers have really taken off a big burden from me.

– Achieng Rose, midwife,
Bulumbi Health Center,
Uganda

WHO Recommendations on Task-Sharing for Family Planning¹

This table summarizes the WHO task-sharing recommendations on the provision of family planning by seven cadres of health workers. Each color represents one of the four categories of WHO recommendations as defined in the key below the table.

	LHWs ³ (CHWs)	Auxiliary Nurses	Auxiliary Midwives	Nurses	Midwives	Associate Clinicians	Doctors
Tubal Ligation	Orange	Orange	Orange	Yellow	Yellow	Green	Green
Vasectomy	Orange	Yellow	Yellow	Yellow	Yellow	Green	Green
IUDs	Orange	Yellow	Green	Green	Green	Green	Green
Implants	Yellow	Blue	Blue	Green	Green	Green	Green
Injectables	Blue	Green	Green	Green	Green	Green	Green
Oral contraceptive pills & condoms	Green	Green	Green	Green	Green	Green	Green

Key to WHO Recommendations:

- WHO recommended as already widely recognized and established practice
- WHO recommended
- WHO recommended with targeted monitoring and evaluation
- WHO recommended only in the context of rigorous research
- WHO recommends against

Allowing CHWs to initiate and reinject injectable contraceptives increases access to family planning for those most in need and helps reduce maternal mortality. With the recommended monitoring and evaluation, CBA2I can be part of a health system that guarantees each individual's right to make fully informed choices about contraceptive use.



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¹ World Health Organization (WHO). 2012. *From Evidence to Policy: Expanding Access to Family Planning. Optimizing the Health Workforce for Effective Family Planning Services*. Geneva: WHO. Available at: <http://www.poplinae.org/node/562090>.

² World Health Organization (WHO). 2012. *WHO Recommendations: Optimizing Health Worker Roles to Improve Access to Key Maternal and Newborn Health Interventions through Task Shifting*. Geneva: WHO. Available at: <http://www.optimizemnh.org/>.

³ The terms "community health worker" and "CHW" used in these resources refer to lay health workers who provide family planning commodities and services. See Resource 1 for a detailed definition.

Conclusions from the WHO Technical Consultation on Expanding Access to Injectable Contraception (2009)

Description: Summarizes the World Health Organization's (WHO) conclusions on provision of injectable contraceptives by community health workers (CHWs), providing policy and programmatic guidance for decision makers.

In June 2009, a technical consultation at the World Health Organization in Geneva concluded that evidence supports the introduction, continuation, and scale-up of community-based provision of progestin-only injectable contraceptives. The group of 30 technical and program experts reviewed scientific and programmatic evidence from Africa, Asia, and Latin America that showed that CHWs can safely and effectively provide progestin-only injectable contraceptives,¹ such as depot-medroxyprogesterone acetate (DMPA). The evidence review focused on three main issues: competency of CHWs; acceptability among clients and providers; and uptake and continuation rates of injectable contraceptives. The review identified 16 CHW projects with documented evidence on these issues from a search of more than 500 articles and 55 additional sources. Independent reviewers rated the quality of the projects' evidence related to outcomes in seven areas: client screening, injection safety, counseling on side effects, client perspective, provider perspective, uptake of services, and continuation of use. Participants in the technical consultation agreed that the evidence in these areas was sufficient and consistent to arrive at five overall conclusions, two key policy implications, and four issues for programmatic guidance, summarized below.¹

Overall Conclusions

- Given appropriate training, CHWs can screen clients effectively, provide DMPA injections safely, and counsel on side effects appropriately.
- Provision of DMPA by CHWs will expand choice for underserved populations and is likely to lead to an increased uptake of family planning services.
- Continuation rates of DMPA by clients of CHWs are as high as those of clients receiving injections at clinics.
- The vast majority of clients express satisfaction with CHW provision of DMPA.
- Trained CHWs are comfortable with their ability to provide DMPA.

ORGANIZATIONS ENDORSING THE CONCLUSIONS

- World Health Organization
- U.S. Agency for International Development
- FHI 360
- International Confederation of Midwives
- International Council of Nurses
- International Federation of Obstetrics and Gynecology
- International Planned Parenthood Federation
- Marie Stopes International
- UNFPA
- The World Bank

¹ The evidence largely focused on the progestin-only injectable DMPA, also known as Depo-Provera, the most widely used progestin-only injectable contraceptive.

Policy Implications

- Sufficient evidence exists for national policies to support the introduction, continuation, and scale-up of community-based provision of progestin-only injectable contraceptives, especially DMPA.
- Operational guidelines should reflect that appropriately trained CHWs can safely initiate use of DMPA and provide injections.

Programmatic Guidance

- Every community-based program should include continued monitoring of provider competency in screening and counseling clients.
- Guidance and supervision of providers enhance their skills and strengthen their confidence.
- Auto-disable (single-use) syringes should be used when available.
- Women should not be denied a progestin-only injectable simply because a means for measuring blood pressure is not available.

Global Need for Injectable Contraception

The technical consultation concluded that community-based provision of progestin-only injectable contraceptives by appropriately trained CHWs is safe, effective, and acceptable. Such services should be part of all community-based family planning programs.

This is particularly relevant because there is still a large unmet need for injectable contraceptives—between 25% and 50% of women who intend to use contraception in the future say they would choose this method.² Establishing or expanding programs for CHW provision of progestin-only injectable contraceptives will help meet this global need.

For more details on the evidence presented and the conclusions from this technical consultation, visit the **Global Evidence** tab on the Knowledge for Health CBA2I Toolkit.



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² World Health Organization, U.S. Agency for International Development, FHI 360. 2010. *Community-based Health Workers Can Safely and Effectively Administer Injectable Contraceptives: Conclusions from a Technical Consultation*. Research Triangle Park (NC); FHI 360. Available at: <https://www.k4health.org/toolkits/fpsuccess/conclusions-technical-consultation-community-based-health-workers-can-safely-and>.

Guide to Resources in the Online CBA2I Toolkit

6

Description: Describes the Community-Based Access to Injectables (CBA2I) Toolkit and selected resources that are especially helpful for advocates.

The Knowledge for Health CBA2I Toolkit is a one-stop source for global guidance and resources about CBA2I advocacy, implementation, and scale-up. The toolkit includes more than 150 resources that can be adapted to specific country contexts and program circumstances. The Advancing Partners & Communities (APC) project manages and updates this toolkit regularly at: <http://www.k4health.org/toolkits/cba2i>.



Knowledge for Health

Key CBA2I Resources in the Toolkit

[Community-Based Access to Injectables: An Advocacy Guide](#)

The guide describes six steps that advocates can take to support policy change to permit community health workers (CHWs) to provide injectable contraceptives. This guide may also be given to donors, family planning/reproductive health professionals, and others who may not be directly involved in advocacy but need to understand the process and the rationale for providing CBA2I. *Located under the **Advocate** tab.*

[Provision of Injectable Contraception Services through Community-Based Distribution: Implementation Handbook](#)

This step-by-step guide describes how to introduce injectable contraceptives to the suite of family planning services offered in an existing community-based distribution program. The handbook details nine essential steps for establishing and managing a CBA2I program. These steps will help policymakers and program managers determine whether and how to provide the service and will pave the way for successful implementation and scale-up. In this handbook, *Step 5: Set Up a Logistical System that Ensures a Steady Provision of Supplies*, and *Step 7: Install Mechanisms that Ensure the High Quality and the Safety of the Service* include details on establishing and maintaining good waste management practices. *Located under the **Pilot** tab.*

TOOLKIT TOPIC AREAS:

- [Global evidence to support the practice](#)
- [Country experiences with CBA2I](#)
- [Advocacy for gaining buy-in and changing policy](#)
- [Piloting, implementing, and scaling up programs](#)
- [Organizations that are global leaders in CBA2I](#)

CBA2I Curriculum and Job Aids

The toolkit includes a sample CBA2I curriculum that program managers can adapt for training, as well as job aids, checklists, and other tools for trainees. This curriculum is updated as needed. *Located under the **Implement** tab.*

Status of CBA2I in Africa Map

The map depicting the status of CBA2I initiatives by country in sub-Saharan Africa can be used as a stand-alone tool to illustrate how the practice has been scaled up throughout the region. This map is kept up-to-date by APC to reflect the latest CBA2I status in Africa. *Located under the **Country Experiences** tab.*

Educational Tour Guidance Package

The Educational Tour Guidance Package was created and used by countries that have hosted or participated in educational tours in the past. Educational tours have proven helpful in advancing CBA2I provision by CHWs in a number of countries. The package includes sample communications documents; a sample agenda and tour program; a budget template; slides and documents with which to develop learning objectives and plans for moving forward; and examples of an executive summary and full summary report for tours. Most of the items are available in Microsoft Word, Excel, or PowerPoint so that they can be easily adapted. *Located under the **Advocate** tab.*

Expanding CBA2I: CHWs Can Initiate and Maintain Injectable Contraceptives PowerPoint Presentation

This PowerPoint presentation contains the WHO Technical Guidance on CHW initiation and provision of injectable contraception, the status of CBA2I programming in Africa, and a summary of findings from CBA2I pilot studies that FHI 360 and its partners have supported. The presentation can be used to inform and gain support for the approach from stakeholders and implementers. The presentation also includes detailed notes to assist the facilitator with presenting the information and answering questions. *Located under the **Advocate** tab.*



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Key Actions for CBA2I Advocacy

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Description: Outlines key activities for promoting community-based access to injectable contraceptives (CBA2I) to inform an advocacy action plan.

Conducting advocacy is an essential part of introducing and scaling up CBA2I programs. Advocacy can help gain buy-in, engage potential partners, and generate support. Successful implementation of CBA2I requires support from the ministry of health (MOH), donors, the local community, and implementing partners, and should ideally work with an established cadre of community health workers (CHWs).

Ways to Advocate for Increasing Access to Injectable Contraceptives at the Community Level

- **Establish a core advocacy team:** Form a small group of individuals who are interested in being advocates for CBA2I. This core team could be a subcommittee of an existing working group that oversees family planning/reproductive health policies and services. It is ideal to include an MOH official on the core team, because ministry support and involvement is essential to obtaining CBA2I approval. The core team should be prepared to address concerns of decision makers and leaders who may need more dialogue and evidence about the practice.
- **Collect data and information on the feasibility and need for CBA2I and the decision-making process:** Collect information from as many available sources as possible. These may include government health reports, other studies on CBA2I, government policies and guidelines on community-based family planning, and location and types of other community-based programs. Conduct in-depth interviews with decision makers and beneficiaries. Understanding the decision-making process and the views of various stakeholders on CBA2I is important for developing an advocacy strategy that will address their concerns.
- **Plan an advocacy strategy:** Discuss the opportunities and barriers identified from the information collected to develop a strategy based on likely decision points and key decision makers. The objective for this strategy should be clearly defined and achievable within a specific time frame. An example of an objective could be to work with ministry personnel to outline the steps necessary to adopt and implement supportive CBA2I policy within three months.

The strategy can include activities such as one-on-one or small-group meetings to address key decision makers' concerns about safety and feasibility. Other activities could present relevant data and information on CBA2I at family planning and maternal and child health technical working group meetings; organize a regional and/or in-country education tour to visit a CBA2I demonstration project; and conduct community health talks to address community concerns and misunderstandings.



Photo: Kebby Hakaminza, Luangwa Child Development Agency, an affiliate of ChildFund

- **Develop tailored advocacy messages:** Identify key decision makers or influential individuals, such as MOH officials, leaders of professional medical associations, and community leaders. Develop clear and concise messages that include recommended actions. The language and tone of the messages should be tailored to each target audience. Key components of a CBA2I advocacy message or set of talking points include a statement of the main concepts being conveyed, evidence that supports the statement, an example of how CBA2I affects an individual at the community level, and the specific action that the individual or group needs to take.
- **Implement the advocacy strategy:** Identify point people or organizations responsible for each activity, agree on a timeline for completion, and ensure that necessary support is in place. Policy environments can change unexpectedly, so messages may need to be revised and relationships with other influential people developed.

The *Community-Based Access to Injectables: An Advocacy Guide*¹ is a wonderful resource for designing and tailoring your CBA2I advocacy strategy. This guide, as well as a range of tools on the Knowledge for Health [CBA2I Toolkit](#), can be used to support these types of advocacy efforts for expanding CBA2I (Resource 6).



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¹ Green, Cynthia P. 2010. *Community-Based Access to Injectables: An Advocacy Guide*. Washington, DC: Futures Group, Health Policy Initiative, Task Order I. Available at: <https://www.k4health.org/toolkits/cba2i/community-based-access-injectables-advocacy-guide>