

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

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, 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>.

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

Senegal

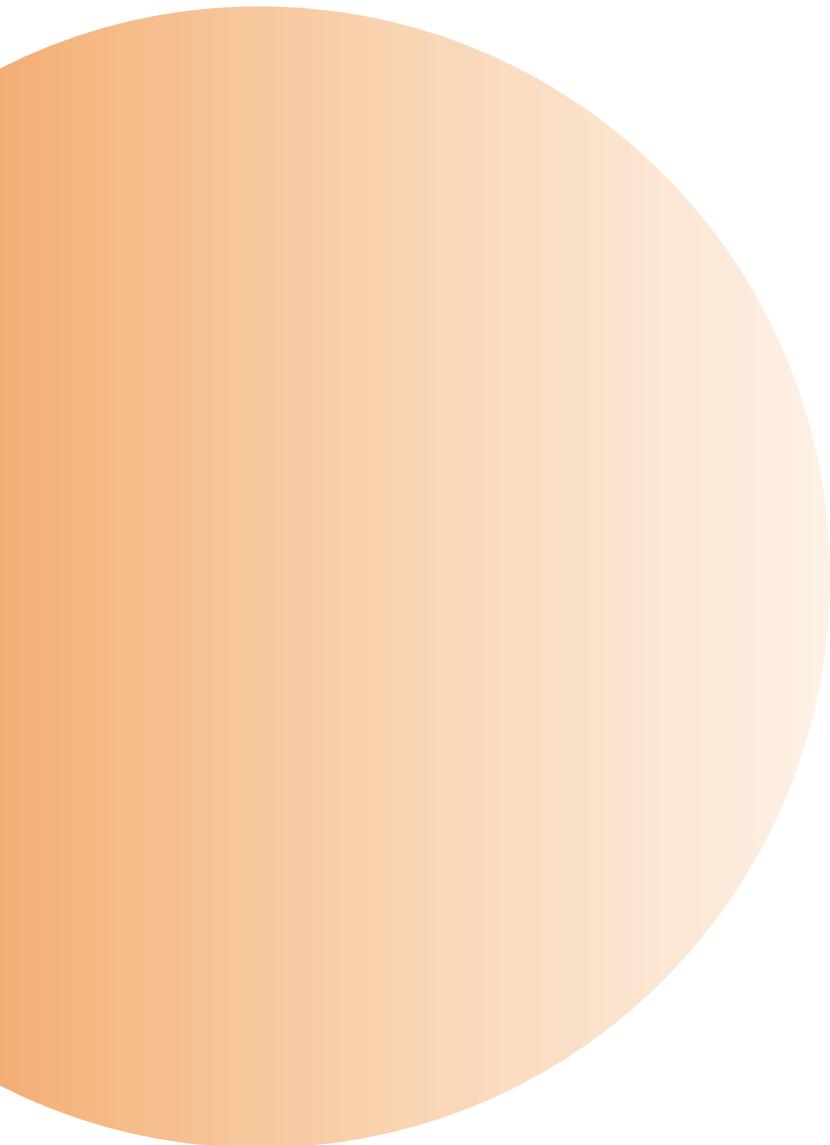
- **Policy change 2010:** Based on the positive results of a 2010 pilot of community-based distribution (CBD) of pills, the Ministère de la Santé et de l'Action Sociale (MOH) revised the national reproductive health policy, norms, and standards document to allow two cadres of CHWs, *agents de santé communautaire* 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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