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Guidance for Integrating the Provision of Injectable Contraceptives by Community Health Workers into Family Planning/Sexual and Reproductive Health Policy

Dr. Nathan Kenya Mugisha, Director of Clinical Services, Uganda Ministry of Health, holding the *Addendum to Section 3.8 Family Planning Service Standards in the Uganda National Policy Guidelines and Service Standards for Sexual and Reproductive Health* allowing injectable contraceptive provision by trained CHWs. © FHI 360

Introduction

National policy documents contribute to the success of health programs by ensuring that service-delivery practices are understood, supported, and institutionalized throughout the health system. Policies provide high-level guidance on what health services should be offered, who should provide them, and where they should be provided. They also outline the specific roles, responsibilities, and limitations of various cadres of health workers.

This brief provides guidance about writing policy to enable the provision of injectable contraceptives by non-clinical community health workers (CHWs). The guidance is informed by the experience of African countries with policies that promote community-based access to injectable contraceptives (CBA2I), such as Ethiopia, Madagascar, Malawi, Senegal, and Uganda. This guidance is intended for use by people who make and influence policy and who are interested in changing national policy to support the provision of injectable contraceptives by CHWs.

Aligning CBA2I Policy with Existing National Policies, Guidelines, and Implementation Documents

Ideally, CBA2I policy should be integrated into broader policy documents on family planning and sexual and reproductive health (FP/SRH) and community health. However, because most countries only review and update these broader policies every five years or more, a policy addendum can be developed that supports CBA2I. Such an addendum was written and distributed in Uganda in 2010 after the Ministry of Health changed its *National Policy Guidelines and Service Standards for Sexual and Reproductive Health* to allow CBA2I. Eventually, the CBA2I policy addendum will be integrated into the FP/SRH and community health policies when they are reviewed and updated.

Writing policy to support the implementation of CBA2I is straightforward. However, ensuring that CBA2I is integrated into other key documents that guide the implementation of family planning service delivery can be time-consuming. Policies, guidelines, strategic plans, and other documents that relate to FP/SRH should be reviewed and updated to ensure that they do not create any barriers to CHW provision of injectable contraceptives. Documents that need to align with the revised FP/SRH policy supporting CBA2I may include:

- **Clinical protocols and guidelines:** ensure they do not contain medical barriers to service provision at the community level and specify the situations in which CHWs should refer a client to higher level providers, for example, to manage certain side effects or to evaluate for certain medical conditions.
- **Screening tools:** confirm that they are appropriate for use by CHWs who do not have formal clinical training.

POSSIBLE PITFALL

Clinical guidelines can create barriers to the provision of injectables by CHWs if unnecessary tests and procedures—such as blood pressure measurement or a physical exam—are required prior to initiation of the contraceptive method. These tests are not needed for safe provision of injectable contraceptives, and CHWs can determine a client's medical eligibility by using a question-based checklist endorsed by the Ministry of Health (WHO/RHR 2011).

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POSSIBLE PITFALL

Screening checklists often contain technical language that CHWs may not understand, which prevents the checklists from being used effectively at the community level. Prototype checklists for injectable contraceptive initiation and continuation are available for adaptation (FHI 2008, 2010a,b).

- **Family planning training curricula and materials:** ensure training guides and job aids are available for CHWs and their supervisors.
- **Supervision models:** ensure that they include supportive supervision for CHWs by qualified type of providers.
- **Logistics and supply chain management plans:** make certain that injectable contraceptives will reach the community level and the CHWs, that CHWs contribute data to inform the plans, and that a resupply mechanism is in place.
- **Record-keeping systems and Health Management Information Systems (HMIS):** ensure that reporting forms for CHWs are simple and available, and that a mechanism exists to channel community-level information to the broader HMIS system.
- **Family planning costed implementation plans:** confirm that funds are allocated for training and supervision of CHWs.
- **Community health policies:** make sure they reflect new services offered by CHWs and specify the selection criteria for CHWs who provide injectable contraceptives.
- **Scale-up plans:** ensure that they support expansion of the new practice nationwide.

COUNTRY EXPERIENCES WITH CHANGING POLICY

MADAGASCAR

Madagascar's Ministry of Health decided to change policy to support CBA2I in 2006 based on evidence from Latin America and Asia demonstrating the safety and feasibility of this practice. Following policy change, the practice was piloted to understand how it should be implemented and scaled up in this country context.

UGANDA

Uganda was the first African country to pilot CBA2I and achieved policy change in 2010—more than five years after the initial CBA2I pilot project. After the pilot was completed, officials required additional evidence on the feasibility of this practice in the country, so implementers expanded service provision to additional districts and monitored it closely. Years of evidence demonstrating the practice was not only safe but feasible across the country was used by several stakeholders within and outside of the Ministry of Health to successfully advocate for policy change.

The Uganda Ministry of Health hosted study tours for four African country delegations to share its lessons learned on the practice including Kenya, Malawi, Nigeria, and Rwanda.

"It all starts with convincing one key person who will be the catalyst [for change]."

Dr. Anthony Mbonye, former head of the Reproductive Health Division, Uganda Ministry of Health (Weil et al. 2008)

NIGERIA

In Nigeria, support for policy change came about after a study tour to Uganda, a local demonstration project, and consistent advocacy with the Federal Ministry of Health. The 2012 London Summit on Family Planning also contributed to the creation of a CBA2I policy in Nigeria, when the Honorable Minister of Health, Prof. Onyebuchi Chukwu, committed to "train our frontline health workers to deliver a range of contraceptives (Chukwu 2012)."

KENYA

In Kenya, strategic and intense advocacy with the professional organizations, such as nurses and midwives associations, which had originally opposed CBA2I, eventually resulted in these constituents leading the successful campaign for policy change and scaling up planning commitments in 2012.

Key CBA2I Issues to Include in FP/SRH Policy

When amending a FP/SRH policy to support CBA2I, common sections that may need revising include the following:

Philosophy and intent of the policy: The FP/SRH policy foreword or introduction section could state that one objective of the policy is to broaden the family planning method mix and choice at the community level, while ensuring both quality and safety of service delivery.

Family planning service provision by level and cadre:

- Lists describing the levels of care for family planning should include the community-level where CHWs operate as well as the community-based service delivery outlets such as health posts, huts, or depots, if applicable to the country context.
- Family planning services provided by CHWs should include counseling, screening, initiation, and continuation of injectables.
- Family planning provider cadres include CHWs. If there is more than one cadre of CHW, all should be clearly listed and the services they can provide clearly stipulated. If more than one CHW cadre type exists, the distinction between their family planning service delivery roles should be stated.

It can be helpful to create a table that lists all of the family planning methods available nationally and indicates which cadre of health provider can provide each. This reiterates the policy language supporting CBA2I and provides a helpful and quick reference. The table may look like the following:

POSSIBLE PITFALL

Include clear language that specifies the range of family planning services that CHWs can provide. If the policy guidance simply says a method is provided "at the community-level" without listing the cadres of providers able to administer that method, confusion could ensue about who is permitted to provide what method. In many countries, multiple providers work at the community level, including auxiliary nurses, midwives, and outreach teams, which can even include doctors.

Table 1. Family Planning Method Provision by Cadre of Staff

Type of Service	Health Promoters & Social Marketing Agents	Community Health Workers	Auxiliary Nurse	Nurse	Midwife	Clinical Officer	Doctor
Counselling	✓[1]	✓	✓	✓	✓	✓	✓
Periodic abstinence methods		✓[2]	✓	✓	✓	✓	✓
Lactational amenorrhea method	✓	✓	✓	✓	✓	✓	✓
Condoms	✓	✓	✓	✓	✓	✓	✓
Combined oral contraceptives		✓	✓	✓	✓	✓	✓
Progesterone only pill		✓	✓	✓	✓	✓	✓
Emergency contraception		✓	✓	✓	✓	✓	✓
Progestin-only injection (DMPA or NET-EN)		✓	✓	✓	✓	✓	✓
Foam tablets		✓	✓	✓	✓	✓	✓
Creams/jellies		✓	✓	✓	✓	✓	✓
Implant insertion and removal			✓[3]	✓	✓	✓	✓
Intra uterine device				✓	✓	✓	✓
Bilateral tubal ligation				✓	✓	✓	✓
Vasectomy				✓	✓	✓	✓

[1] Counselling on some methods such as condoms and LAM but will require special training
[2] Specifically Cyclebeads and not all periodic abstinence methods
[3] Will require special training and close supervision

ADDITIONAL RESOURCES

Read these additional resources to learn more about how to promote CBA2I and advocate for policy change:

- Provision of Injectable Contraception Services through Community-Based Distribution: Implementation Handbook (Weil 2008)
- Community-based Access to Injectables: An Advocacy Guide (Green 2010)
- Key Actions for CBA2I Advocacy from the CBA2I *Advocates Package* (APC 2014)
- The Community Health Systems Catalog, which contains links to existing CBA2I policy documents for many countries.

JSI Research & Training Institute, Inc.

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Training:

- Consider adding training requirements for CHWs who will provide injectable contraceptives, such as the minimum length of training, a schedule for refresher training, and how many injections should be administered under supervision before they can provide this method unsupervised.

Human resource development:

- Consider adding minimum recruitment and selection criteria for CHWs who administer injectables, such as age, familiarity with the community, and minimum literacy level.

Supervision of family planning services:

- CHWs providing injectable contraceptives may require more supportive supervision than other CHWs. CBA2I policy language should include guidance on the development and implementation of appropriate supervision plans with clearly defined roles and responsibilities, as well as performance indicators.

Monitoring and evaluation:

- Consider adding language that instructs district and local health services to develop plans for tracking and reporting community-level health service delivery data to the HMIS. Record-keeping and reporting systems at the community level can differ from ones at the higher level of care.

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