Expanding Access to Family Planning Services at the Community Level

Findings and Recommendations From a Regional Assessment

ECSA-HC
East, Central and Southern Africa Health Community

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Foreward

This assessment on expanding access to family planning (FP) at the community level in five member states, coupled with the presentation and rich discussion from four other member states made during the dissemination workshop, was the first regional attempt to describe policy and service delivery guidelines that facilitate delivery of quality FP services at the community level; to identify challenges and opportunities in addressing FP needs of underserved populations; and to synthesize commonalities for improved approaches to expanding FP services, for the ECSA region.

This assessment came in response to several health ministers' resolutions, the International Conference on Family Planning in Kampala in November 2009, and a meeting of multiple countries in Kigali in March 2010. The findings of this assessment also build on the urgent need to achieve MDG 5b, by providing FP services to the majority of the population who lives in the underserved rural communities. Improving access to FP services is a promising practice that would contribute to the achievement of all eight millennium development goals.

The recommendations made from the findings of this assessment will form a basis to re-engage the health ministers so that they take further decisions on implementation of the recommendations through relevant resolutions. The region needs urgent measures to avert the high unmet needs for family planning, the low contraceptive prevalence rates, and consequent high fertility rates that tend to reverse any meaningful economic gains in the continent. It is our sincere hope that these findings will contribute to the growing knowledge and understanding of best practices that will enhance the expansion of FP services to the areas where they are needed most – and that they will encourage innovative and practical ways to expand services to underserved communities.

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August 2011

Preface

Family planning services are lacking at the community level, where the majority of the population lives in the region. This is not in doubt. The services in the rural regions are much poorer than those of their urban counterparts, and the infrastructure in these communities is appalling. The total demographic picture in each country, therefore, depicts more of the rural than the urban measures. The health care workforce in the rural areas is much smaller than what is seen in the urban areas, drifting further from the recommendation of the World Health Organization of a health care worker ratio of 2.5/1000 population. The need to review the current policies, guidelines, and financing issues that address quality health service delivery at the community level has become imperative. The main purpose of this assessment was therefore to inform the policies, practices, and financing to enhance the expansion of FP service delivery to the majority of the population in the region.

The assessment has shown that FP is usually not a priority service within the essential health packages. It further showed that the nomenclature for community health workers (CHW) varies widely across the region. The period of training and the services provided by CHWs vary considerably from country to country. Financial constraints contribute to challenges in increasing coverage of community services, and most of our countries depend on donors to fund the FP services. National guidance on training, remuneration, and types of services vary for the cadres of staff that provide them at the community level. Guidelines for supervision of CHWs also vary extensively. Failure to involve men and youth in the service delivery was also noted as a major handicap.

The assessment has shown that expanding FP services at the community level has clear benefits in improving access to family planning information and services. Therefore, this approach is a powerful tool for social transformation towards improved quality of life at the community level. While promising practices and models are emerging, much remains to be done.

The recommendations made from this assessment will set a firm platform on which the region should build on to accelerate the achievement of the MDGs

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August 2011

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List of Abbreviations and Acronyms

ANC	Antenatal Care
CBDA	Community Based Distributor Agents
CBFP	Community Based Family Planning
CBHC	Community Based Health Care
CHW	Community Health Worker
DHMT	District Health Management Team
DHS	Demographic Health Survey
DMOH	District Medical Officer of Health
ECSA-HC	East, Central and Southern Africa Health Community
FP	Family Planning
HSA	Health Surveillance Assistant
MDGs	Millennium Development Goals
PHC	Primary Health Care
RH	Reproductive Health
SRH	Sexual and Reproductive Health
SWAp	Sector-Wide Approach
WHO	World Health Organization

Executive Summary

Expanding access to family planning (FP) at the community level is a priority strategy for accelerating progress toward achieving Millennium Development Goals (MDGs), particularly goal 5b, universal access to reproductive health, including family planning (FP). Emphasis on community access to FP has emerged as a major goal in sub-Saharan Africa specifically, most recently in the March 2010 meeting among 12 African nations at Kigali. At the Kigali meeting, participating countries reached consensus that community FP should be the priority strategy for expanding access to FP to address unmet need and accelerate progress toward the MDGs. This strategy resonates with earlier calls for action in the region, including a number of key resolutions by East, Central and Southern Africa Health Community (ECSA-HC) health ministers, the Maputo Plan of Action, and the 2009 International Conference on Family Planning held in Uganda.

In the 2008 resolution ECSA/HMC 46/R4, member states (MS) were urged to allocate/increase financial resources for FP and to reduce unmet needs by 10% by 2010; and to develop and implement policies, guidelines, and training curricula on task shifting among health care providers by 2011. The secretariat was directed in the same resolution to develop and implement policies and guidelines on task shifting among health care providers by 2010. In the 2009 resolution ECSA/HMC 48/R5, the health ministers urged MS to advocate for increased political and financial commitment to FP by December 2011; and to develop country-specific policies and guidelines on task shifting by December 2012 for the delivery of SRH and FP services to ensure access to FP services for the poor, marginalized, and underserved communities. In the same resolution the secretariat was to support member states to develop and/or adopt advocacy, costing, and modeling tools; and to document and disseminate promising and best practices in FP with links to proven effective practices.

ECSA has been working with its member states to address issues related to expanding access to family planning. ECSA coordinated a regional assessment project, including five country assessments (Kenya, Lesotho, Malawi, Uganda, and Zimbabwe) and a regional dissemination and validation meeting where representatives from four other member states reported their status expanding access to FP services at the community level (Mauritius, Swaziland, Tanzania, and Zambia). This report therefore includes issues and recommendation from nine ECSA member states. FHI 360 provided technical assistance on these assessments and led the assessment in Kenya. These five assessments used a desk review, key informant interviews, and focus group discussions. The regional dissemination and validation meeting included presentations, discussions, and a consensus building process around the regional recommendations.

In the ECSA region, the majority of the population lives in the rural areas, where health services are poor compared to those in urban areas. For example, in Malawi, four in every five people live in rural areas, and most of them need services at the community level due to poor transportation systems and long distances to district and other lower health facilities. All ECSA countries face similar challenges. The rural-urban demographics have a major impact on key indicators for meeting the MDG 5b goal of universal access to reproductive health, including FP. The rural areas have fast-growing youth populations, high unmet need for FP, high total fertility rates, high maternal mortality rates, and high rates of unintended pregnancy. Urban areas have better rates in all of these measures.

In all five assessments and in the regional meeting, common themes arose as challenges to expanding access to FP at the community level. The main general barriers identified were: poverty and lack of FP knowledge, socio-cultural issues, contraceptive method mix, inadequate male and youth involvement, inadequate political support, and inadequate financial and human resources. The main challenges to expanding access to FP services at community level, specifically were: limited number of methods provided by CHWs, low motivation and retention of CHWs, inadequate supervision and training, concerns from regulatory groups, inadequate commodity security and logistics, and poor infrastructure.

Despite the challenges, a number of opportunities for expanding access to FP services at the community level emerged during the assessment. The main ones were: national policies are moving towards integrated services, community engagement enhances services, many stakeholders support community FP services, CHWs help expand access, and clients prefer getting services closer to home.

A synthesis of the material gathered through the regional assessment led to key findings and accompanying recommendations. These included eight issues related to policies, guidelines, strategies, and financing, and 10 issues addressing operational issues. The findings are listed below and discussed in section 3 of the report. They are followed below by the recommendation for each, from section 5 of the report. Comments from CHWs themselves, shown in section 4, also informed the recommendations.

Policies, Guidelines, and Strategies

1. Some countries have essential health packages to be provided by CHWs, but FP is usually not a priority service.
   Recommendation: *Include FP services explicitly as a priority in these packages.*

2. CHW cadres vary extensively, including length of training, remuneration, and types of services provided.
   Recommendation: *Develop prototype policy and operational guidelines on these issues.*

3. Some country policies are not consistent with global and regional evidence in terms of the provision of all methods, including injectables, by CHWs.
   Recommendation: *Review country policies so that they are based on evidence.*

4. Regulatory and professional associations expressed concerns about CHWs, especially in the length of time for training CHWs. These associations cannot regulate these health workers if they are trained for less than one year. Ministry of Health officials pointed out that they are responsible for regulating those CHWs employed by the MOH, including those trained for less than one year.
   Recommendation: *Address these concerns of the associations.*

5. Research and experience is limited on pharmacists and drug shops as sources of contraceptives at the community level.
   Recommendation: *Conduct research including a needs assessment on options for policies and guidance on this issue.*

Financing

1. Financial constraints contribute to challenges in increasing coverage of community services.
   Recommendation: *Generate country specific ways to track financing of reproductive health (RH), including FP, such as a national health account, subaccounts on RH, line item funding, or ring funding for FP.*

   Recommendation: *Develop a regional advocacy toolkit that countries can adopt and adapt to advocate for more FP funds.*

7. Most of the ECSA countries are dependent on donor funds to provide FP services, especially those at the community level.
   Recommendation: *Develop ways that countries can gradually absorb FP programme costs, using such tools as costed implementation plans that include providing FP services at the community level.*

8. Some countries fund FP as a lower priority than emergency health areas.
   Recommendation: *Where possible and not currently functioning, member states should establish a government agency with a mandate to focus on FP at the policy and financing level, similar to the national AIDS control programs.*

Operational Issues

1. National guidance on training, remuneration, and types of services varies for the cadres of staff that provide services at the community level.
   Recommendation: *Develop a regional service delivery package that provides discrete guidance on CHWs and FP. Such a package should define the roles of the health cadres, as well as non-health groups such as teachers, police, youth peer educators, and military personnel.*

2. Guidelines for supervision of CHWs vary extensively.
   Recommendation: *Develop supervision guidelines and generic tools that can be adapted by member states, including guidelines on proper training of CHW supervisors.*

3 FP information and services from CHWs are often not linked well with facilities.
   Recommendation: *Develop clear referral structures and linkages between the community and facilities (and vice versa), including linkages with maternal and child health systems.*

4. CHWs and others reported problems with motivation and turnover.
   Recommendation: *Address issues related to sustainability, motivation, and remuneration, including in-kind services such as transport, actual remuneration, possible career paths, refresher training and supervision, and innovative approaches such as access to credit and community cooperatives.*

5. Regular supplies of commodities is a problem in most countries.
   Recommendation: *Improve systems that can ensure continued supply of commodities to the CHWs, such as community depots and monitoring systems, both of which require strong community commitment. Countries should pay attention to the demand from the community, known as the "pull system" and not rely exclusively on a central quota system, known as the "push system."*

6. Men can be barriers to FP services in the community.
   Recommendation: *Strengthen efforts to engage men at the community level, including individual or couple discussions, having male CHWs, and engaging village councils and other forums that are often led by men.*

7. Youth make up a large part of potential clients but are underserved.
   Recommendation: *Engage unmarried, sexually active youth and newly married youth through peer educators, youth centers, and other linkages*.

8. Nurses/midwives organizations said they are not involved sufficiently in community services.
   Recommendation: *Involve nurses/midwives and their regulatory authorities and professional associations in training and supervising CHWs, as well as providing services at the community level.*

9. CHW activities with FP are not monitored well.
   Recommendation: *Provide guidance on monitoring and evaluation of community-based FP including dropout rates of lower level and unpaid CHWs, work load pressures of CHWs, and new research on motivation of CHWs.*

10. Community mobilization is important for successful CHW programs.
    Recommendation: *Provide regional guidance on community mobilization approaches such as community gatherings, contests, and other events.*

The assessments show that community-based FP has clear benefits in improving access to family planning information and services. Therefore, this approach is a powerful tool for social transformation towards improved quality of life at the community level, including improvement in the contraceptive prevalence rate and the resulting impact on maternal and child health. While promising practices and models are emerging, much remains to be done.

1.0 Introduction

1.1 Background

Expanding access to family planning at the community level is a priority strategy for accelerating progress toward achieving Millennium Development Goals (MDGs), particularly goal 5b – universal access to reproductive health, including family planning (FP). Emphasis on community access to FP has emerged as a major goal in sub-Saharan Africa. In the March 2010 meeting in Kigali, 12 African participating countries reached consensus that community FP should be the priority strategy for expanding access to FP to address unmet need and accelerate progress toward the MDGs.

Women in rural areas have a particularly high unmet need for FP services, especially during the postpartum period. A review of data from 27 Demographic and Health Surveys (DHS) found that 67 percent of women who gave birth within the previous year had an unmet need for family planning. One way to address this is by strengthening systems that can make FP services more available to the communities. Some approaches have worked successfully to address the critical shortage of medical professionals and to expand access to a range of health services, such as empowering cadres of health workers who have not undergone the regular medical training programmes to provide FP services at the community level. In this concept of skills transfer or delegation of skills (known as task sharing or task shifting), which has been endorsed by WHO, providers with less medical or paramedical training can deliver some prescribed services with the same quality as providers with more medical training.

The ECSA-Health Community has addressed issues related to expanding access to FP services at the community level. In 2008, the 46th ECSA Health Ministers Conference (HMC) adopted resolution ECSA/HMC 46/R4, which urged member states to allocate/increase financial resources for FP and to reduce unmet needs by 10% by 2010. The resolution also urged member states to develop and implement policies, guidelines, and training curricula on task shifting among health care providers by 2011, which would allow mid-level cadres to carry out specifically identified activities that shift non/less technical duties from mid-level to lower-level cadre staff, such as community based distributors of contraceptives. In the same resolution the ECSA secretariat was directed to support countries to develop and implement policies and guidelines on task shifting among health care providers by 2010.

In 2009, HMC, through resolution ECSA/HMC 48/R5, urged member states to advocate for increased political and financial commitment to FP; ensure the full integration of FP into national development plans and poverty reduction strategies; and to develop costed implementation plans for sexual and reproductive health (SRH) services informed by the Maputo Plan of Action, by December 2011. It also called on the member states to develop country-specific policies and guidelines on task shifting by December 2012 for the delivery of SRH and FP services to ensure access to FP services for the poor, marginalized, and underserved communities. The resolution also directed the secretariat to support member states to develop and/or adopt advocacy, costing, and modeling tools; document and disseminate promising and best practices in FP with links to proven effective change practices; and assist member states to implement various international instruments such as the Maputo Plan of Action and the African charter on the rights of the woman. All country signatory to such documents are required to report against the indicators and targets in these documents.

1.2 Objectives

The regional assessment, conducted in 2010-2011, sought to:

- Describe national level policy and service delivery guidelines/standards that facilitate delivery of quality FP at the community level.
- Identify challenges and opportunities in current community-level FP service delivery systems in addressing FP needs of underserved populations.
- Synthesize commonalities for improved approaches to expanding FP services to inform country and regional priorities for improved service delivery of FP services.

1.3 Methodology

To address ECSA resolutions and other international commitments and recommendations related to community-based FP, ECSA worked with the Ministry of Health in five member states – Kenya, Lesotho, Malawi, Uganda, and Zimbabwe – to assess current policies, guidelines, financing, training materials, and implementation of community-based FP. Family Health International (FHI 360) provided technical assistance to ECSA for the five assessments and led the process in Kenya. Country reports were prepared for each of the five countries. These five assessments, which took place during 2010-2011, drew on two primary sources:

1) Desk review of related literature, including DHS data, policy documents, national guidelines, research studies, and program reports; and

2) Qualitative input from key informant interviews and focus group discussions. The interviews and focus group discussions followed interview guides. The interviews were conducted with policy-makers, professional associations, regulatory boards, implementing agencies, donors, members of Parliament, providers, and community health workers (CHWs).

In addition, in June of 2011, ECSA sponsored a regional dissemination workshop based on these five reports; at the meeting, representatives of the Ministry of Health from four other ECSA member states – Mauritius, Swaziland, Tanzania, and Zambia – added information for consideration in the regional assessment through presentation of their status on expanding access to FP services in their respective countries. This report therefore, covers the issues of access and recommendations to FP services for nine ECSA member states.

1.4 Reporting on the Regional Assessment

In July 2011, ECSA produced a poster and brochure summarizing the findings and recommendations from the regional assessment, and presented this information at the USAID-sponsored meeting focusing on community based family planning, held with country teams in Nairobi, July 2011. ECSA also produced a report of the regional dissemination workshop held in Lilongwe in June 2011, where teams from eight of the 10 ECSA countries validated the findings and recommendations presented in this report.

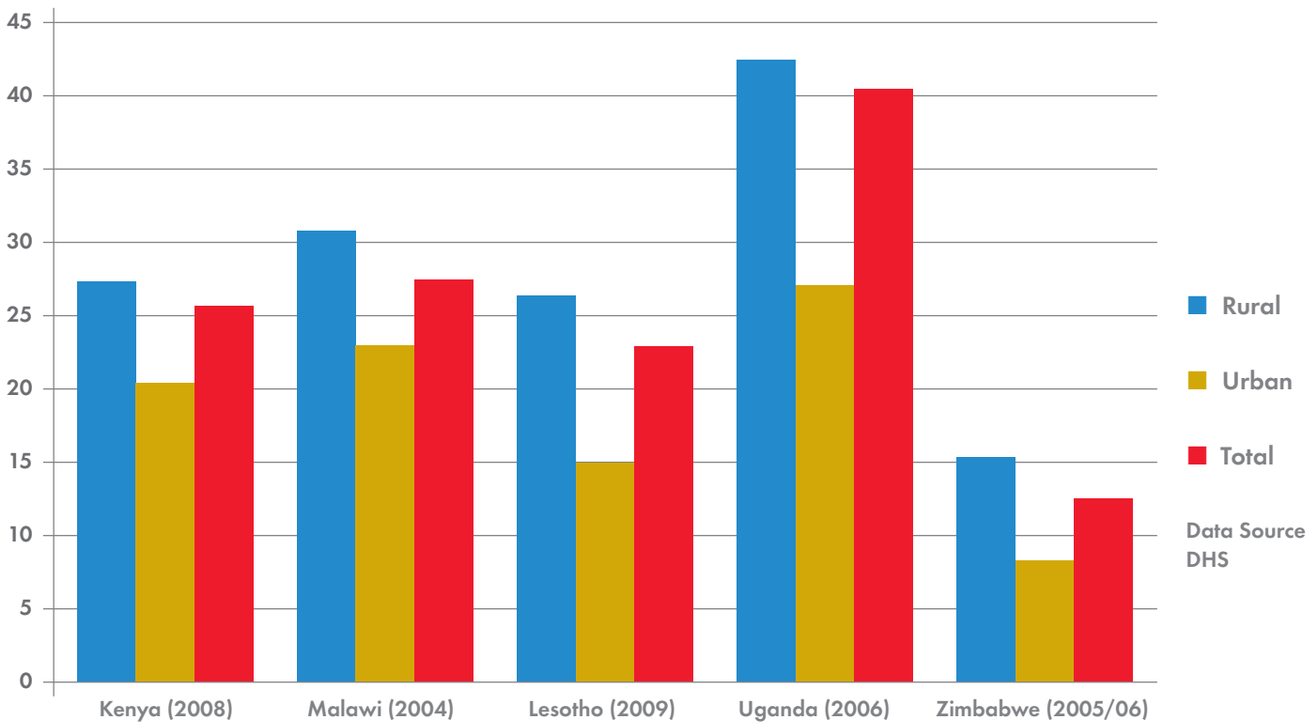
▼ 2.0 Rationale

In the ECSA region, the majority of the population lives in the rural areas, where health services are poor compared to those in urban areas. For example, in Malawi, four in every five people live in rural areas, and most of them need services at the community level due to poor transportation systems and long distances to district and other lower health facilities. All ECSA countries face similar challenges.

The rural-urban demographics have a major impact on key indicators for meeting the MDG 5b goal of universal access to reproductive health, including FP. The rural areas have fast-growing youth populations, high unmet need for FP, high total fertility rates, high maternal mortality rates, and high rates of unintended pregnancy. Urban areas have better rates in all of these measures.

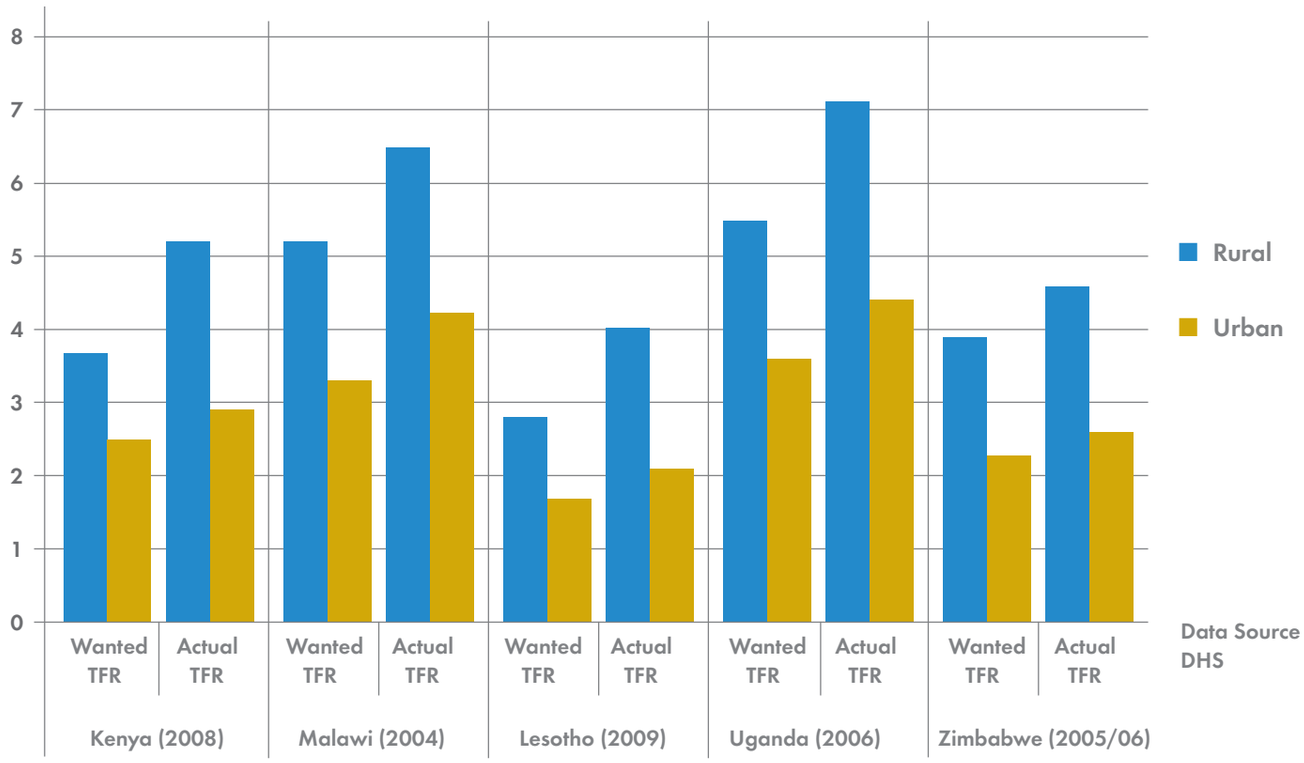
The unmet need for family planning in the five assessment countries shows a sharp contrast in access to contraception between rural and urban areas (see Figure 1). Unmet need refers to the percentage of women who are at risk of pregnancy but not using contraception. The difference between rural and urban rates is particularly wide in Lesotho and Uganda. The other notable point from Figure 1 is the fact that the overall percentage for the country is much closer to the rural than to the urban area, because of the percentage of the population in the rural area and the poorer service delivery systems, compared to those of the urban counterparts.

Figure 1. Unmet Need for Family Planning (percentage of married women of reproductive age)



The rural-urban contrast is equally striking when looking at total fertility rates across the five countries (see Figure 2). Total fertility rate (TFR) refers to the number of children a mother has had over her reproductive lifetime. Figure 2 also shows the sharp difference in the wanted TFR and the actual TFR. In Kenya, for example, the wanted TFR is nearly four children in rural areas but about 2.5 in urban areas. In contrast the actual TFR is more than five in rural areas but not quite three in urban areas. In Uganda, the actual TFR is more than seven in rural areas, compared to just over four in urban areas.

Figure 2. Total Fertility Rate (percentage, married women of reproductive age)



One of the key indicators in addressing health needs is the number of health workers in a country. The World Health Organization (WHO) recommends 2.5 health workers to 1000 population; all five countries assessed are far from meeting this goal. In Malawi, for example, the ratio is 0.3 health workers per 1000 population, well below the 2.5/1000 threshold. Adding in community health workers (CHWs), the ratio is 1.03 health workers per 1000 population. Note the importance of adding in the CHW to approach a better ratio – still far below the WHO recommendation but much better than without including them.

This urban-rural contrast in sub-Saharan Africa, combined with the shortage of highly trained health workers, lends greater importance to expanding access to family planning services at the community level. The countries covered by this regional assessment need to seek ways to expand access to contraception, especially in rural areas. Greater access in rural areas provides an important way to help women achieve their own pregnancy goals and to help a country meet its MDG goals.

▼ 3.0 Assessment Findings

3.1 Challenges and Opportunities

From all five countries assessed, as well as information from the regional meeting, common themes arose as challenges to expanding access to FP at the community level. The challenges include general barriers to FP services as well as those specific to community level services. In addition, opportunities for expanding FP services in the community arose during the assessments.

3.1.1 General Barriers to FP Services

Poverty and Lack of FP Knowledge. "Family planning is not achieving what it's supposed to achieve," said Honorable Paul Chibingu, chair of the Malawi Parliament Committee on Health, during a group session with six other Parliamentarians. "Some believe having children is the only way the village can grow. Some religious teachings do not promote family planning." At the same time, he noted, people have accepted FP in some areas and acquired services. The Parliamentarians noted that high poverty levels and illiteracy in rural areas contribute to lack of civic education. "People are not told what family planning is all about."

Socio-Cultural Issues. Larger families are desirable in some areas, especially where livestock are central to communities. "People still believe that their children are supposed to provide labor, especially in cattle producing areas," mentioned one district-level respondent in Uganda. Child survival is also a factor. As one Ugandan MP said, "I asked a certain gentleman in the village that, why do you have so many children like this? And he said that you see I produce so many children so that when some die, I still have some to stay with me." Other factors mentioned by respondents as a barrier to FP use were religion, stigmatization of contraceptives, polygamy, and women's empowerment. A Ugandan MP said that in rural areas, "some people think that using contraceptive pills or condoms is for people who are prostitutes."

Contraceptive Method Mix. The assessments found that countries rely on short acting methods, without enough attention to IUDs, implants, or sterilization. In Lesotho, for example, respondents pointed out that providers lack skills in providing longer acting methods, as well as essential equipment and supplies. Also, the high HIV rates in countries like Lesotho lead to an emphasis on condom promotion for dual protection, especially among youth.

Inadequate Male and Youth Involvement. Respondents in all countries commented on the need to engage men and youth more, to support the idea and need for family planning. Economic issues are outstripping the pace of more children, said Dr. Zawaira of the Malawi World Health Organization office. "You need to teach households …. What are my responsibilities toward these children? Can I afford to take care of them? And how does this affect the development of the country?" For such efforts, he said, "You have to engage the men. Men need to be involved in family planning discussions. There needs to be discussion between men and women. And, we have to start socializing the boys as early as possible."

Inadequate Political Support. While some political support is strong for FP, other politicians encourage high fertility, especially at the district level, saying that a higher population will lead to greater resource allocation. A District Health officer in Uganda explained that local politicians say that those who have more children get a prize, such as a piglet. "It was something like a competition in that district."

Inadequate Financial and Human Resources. Levels of funding for family planning are not a high enough priority in any of the countries assessed, which leads to lack of human resources throughout the system, both clinics and communities. None of the five countries assessed had any dedicated line item or subaccount for family planning, a costed implementation plan (as does Tanzania), or a FP fenced system for funding.

3.1.2 Challenges to Expanding FP Services at the Community Level

Limited CHW Coverage for FP. In Malawi and Uganda, community health workers can provide injectable contraception at the community level. In Kenya, Lesotho, and Zimbabwe, the CHWs can only provide pills and condoms. The Kenya Ministry of Health did sponsor a pilot for CHWs to provide injectables, and findings were positive, but the MOH has not yet altered the policy to allow this practice to continue and expand.

Low Motivation and Retention of CHWs. Respondents felt that the CHW systems in most countries were not sustainable, without some increase in rewards, including remuneration, to increase motivation for CHWs and enhance retention. Also, CHWs themselves identified challenges to a volunteer system, as it functions in Uganda. "It is difficult volunteering our time and not being compensated," a CHW said during a focus group discussion. "Also the reimbursement for the transport cost to obtain re-supply is not sufficient. For those of us who have bicycles, any repairs are done at our own cost." Other related issues include the workload of CHWs without compensation, unfilled expectations of non-monetary incentives, and the attrition rates when a CHW can get a job.

Inadequate Supervision and Training. Respondents pointed out that due to human resource shortages, many CHWs do not receive regular supervision. This affects morale of the CHWs, as well as various service issues, including refresher training and support. Also, training is often too short and irregular, depending on the funding of an NGO that is expanding a service, using MOH-funded or volunteer CHWs.

Concerns from Regulatory Groups. Medical, nursing, and midwifery councils interviewed expressed concern about CHWs providing FP information and services, primarily because of the short length of training and the lack of a clear regulatory framework. As the registrar of the Nurses and Midwives Council of Malawi said, "We understand the need for the HSAs [Health Surveillance Assistants]. We don't have the numbers of nurses/ midwives to reach out to the remote areas. We support them but want them to be trained properly. We need a regulatory framework." In Lesotho, Malawi, and Uganda, the medical boards expressed their reservations in setting a regulatory framework for CHWs, given the short length of training for the CHWs. Their recommendations were that CHWs be trained for at least one year and for the councils to set the regulatory systems for them.

Inadequate Commodity Security and Logistics. Stock-outs present challenges at both the facility and community levels. Groups in several countries expressed concern about future contraceptive security in light of rising demand and increased service delivery at the community level. A donor questioned how contraceptive security could be assured at the community level when even facilities are experiencing stock-outs. According to a JSI report, the most common reason for stock outs in some countries is lack of central level supplies. Supplies are often transported between health facilities when higher levels are stocked out. With DMPA, sometimes CHWs get DMPA but no syringes. In this case, they must ask their clients to buy syringes which can create the impression that clients have to pay for the services.

Poor Infrastructure. Poor roads, distance to clinics, and mountainous terrain in some countries all contribute to poor community access to FP services. CHWs themselves have trouble getting to clinics or depots for resupplies of commodities, due to these difficult terrains.

3.1.3 Opportunities for Expanding Community FP Services

The findings from the assessment identified some opportunities to overcome the various barriers discussed above. Community engagement was widely seen as perhaps the most important overarching factor that can facilitate greater access and use of FP in local isolated areas.

National Policies Are Moving towards Integrated Services. In Kenya, Malawi, and Uganda, national policies are moving towards providing a package of essential health services through CHWs. Some cadres, such as the HSAs in Malawi have experience in providing child immunization, for example, which helps them to provide injectable contraceptives.

Community Engagement Enhances Services. Dr. Nathan Kenya-Mugisha, the acting MOH Director General of Health Services in Uganda, puts the issue simply, "Working with communities is the answer." By engaging the

community, more support emerges, assessment respondents said. A member of Parliament in Uganda said that sensitization is particularly needed around men's involvement in FP. He recalled a successful national radio campaign that encouraged men to see the benefits of smaller families by using humor to compare the difficult life of one man who had not used FP and had many children, with the life of another man who had a small, manageable family. Women's groups and drama clubs could also provide an effective venue in which communities can engage in sensitization efforts.

Many Stakeholders Support Community FP Services. Many respondents said that providing FP services at the community level is acceptable to national and district-level stakeholders. The respondents believe that the provision of FP at the community level is beneficial and recognize the potential of utilizing this strategy to expand access to FP in underserved areas. "There are very many people who were against this community-based distribution of injectables," says Dr. Anthony Mbonye, Uganda Commissioner for Community Health. "Now they have changed their minds, having seen that it works."

CHWs Help Expand Access. Key informants identified certain characteristics of community-level FP providers and the positive effects that a CBFP program may have on the community. "[CHWs] are cheap to train, easily acceptable in the community setting; they know how to speak the local language to convince the husbands, the youths and the wives on the need to use family planning services in the village," explained a regulatory board member in Uganda, who supported existing programmatic and research evidence that CBFP is acceptable to clients.

Clients Prefer Getting Services Closer to Home. Clients prefer to get services nearby where they can actually access them, said respondents. Moreover, CHWs themselves explained their ability to increase community members' acceptance of FP and dispel myths, thereby helping to address some of the socio-cultural barriers to uptake. "The community was initially skeptical about FP due to misconceptions, but we have been able to sensitize people, particularly men, on the benefits of FP," said a CHW from Uganda during a focus group discussion. A Lesotho village health worker said, "Community members appreciate the work we do because they come to seek services even at night from us."

3.2 Policies, Guidelines, Strategies, and Financing

The five country assessments and the regional dissemination meeting identified and highlighted a number of issues related to policies, guidelines, strategies, and financing. These findings can be grouped into five categories related to policies, guidelines, and strategies, and another three areas related to financing.

3.2.1 Essential Health Packages

Some countries have essential health packages to be provided by CHWs, but FP is usually not a priority service. In Kenya, for example, the different types of community based distribution (CBD) agents are being grouped into a broader CHW cadre that has responsibility for a broad essential health package of services. Initially, the CHW Essential Health Package under consideration did not clearly delineate FP services as a priority. Partially as a result of the assessment in Kenya, the need to articulate clearly the responsibilities for FP within the CHW essential package of services became clear. That proposal is included as an appendix to the Kenya country assessment report.

3.2.2 CHW Cadres Vary Extensively

CHWs are not a uniform group. They vary in three main areas: whether they are a part of the country health system (and hence paid) or are totally community volunteers; the length of training they receive and their education requirements; and the type of services they are allowed to provide. Malawi has a two-cadre system: the HSAs are the lowest MOH level and are paid, while the community based distribution agents (CBDAs) are not paid and are pure community volunteers. Uganda, in contrast, has a village health team approach, which is a single cadre system with the same range of duties as the HSAs. A central theme arising from the assessments and the regional meeting was the need for a regional guidance on standardized training levels for different types of cadres.

3.2.3 Country Policies Not Consistent on Injectable Contraceptives

The assessments and regional meeting discussions emphasized the contrasting views about the role of CHWs in expanding access to injectable contraception at the community level. In Malawi and Uganda, community health workers can provide injectable contraception at the community level. In Kenya, Lesotho, and Zimbabwe, the CHWs can only provide pills and condoms (although Kenya is considering the option of CHWs providing injectables, following a successful pilot). The MOH representatives at the regional meeting agreed to recommend that Ministries should make their policies consistent with global and regional evidence on this issue, which have shown that CHWs can provide this service effectively, safely, and with equal competence to clinical providers, with sufficient training.

3.2.4 Regulatory and Professional Associations Have Concerns

Medical, nursing, and midwifery councils interviewed expressed concern about CHWs providing FP information and services, primarily because of the short length of training and the lack of a clear regulatory framework. The councils expressed this concern in all the countries assessed. At the same time, some of those interviewed acknowledged that there weren't enough nurses/midwives to meet all of the FP needs in rural areas, nor were nurses/midwives always willing to serve in these areas. Regarding the issue of regulation, the Deputy Director of the Reproductive Health Unit, MOH in Malawi, made this point at the regional dissemination meeting: "If a community health worker is employed by the Ministry of Health [as the HSAs are in Malawi], the Ministry of Health is responsible for regulating this worker." This rationale would apply to the CHWs in Kenya or the Village Health Workers in Uganda, for example, who are under the responsibility of the MOH, although remuneration issues vary.

3.2.5 More Information Needed on Pharmacists and Drug Shops

Pharmacies and drug shops are widely used at the community level as sources of contraceptives and sometimes as locations for receiving injectables of various sorts, including DMPA. Limited research on this issue exists, and regulatory issues vary among countries. Issues include over-the-counter sale of oral contraceptives without prescription, quality of care of drug shop owners who are giving injectable contraceptives, and various regulatory issues for drug shops/pharmacies.

3.2.6 Financial Constraints Limit Coverage of FP Services

Financial constraints contribute to challenges in increasing coverage of community services. The five assessments found that no country had a system that could identify clearly the amount allocated for FP/RH. No country has a FP "ring funding" system that kept the FP funds separate from a larger pot of resources for health, or a national health account with a line-item budget for FP. Also, existing advocacy documents did not focus specifically on financial issues.

3.2.7 Countries Are Dependent on Donor Funds

The assessments and regional meeting focused on the need for countries to take more ownership of community FP, including allocating country funds for this purpose. Currently, countries depend significantly on donor funds and limited-time projects such as a USAID-funded bilateral. This means that training and often in-kind support comes through an international NGO, which makes long-term support for the health system uncertain. Tools mentioned that can help track country investment include a costed implementation plan, such as the one developed in Tanzania, and now being monitored to see its effectiveness to influence the Ministry's funding there.

3.2.8 Funding for FP Is a Low Priority

The assessments and regional meeting pointed out that funding for FP is not a priority in the health sector. Countries tend to focus on health priorities, such as AIDS care and treatment, and often set up national agencies to track such priorities and advocate for such programs and funding. An example is the national AIDS control programme model, which exists in many countries. Discussions focused on whether countries have the political will to establish some similar mechanism that would focus on FP in general, much less community-based services.

3.3 Operational Issues

ECSA focuses on the policy level in its work with member states, and the regional assessment focused largely on policies, guidelines, and strategies. However, inevitably, the discussions at the policy level reached into operational issues. In fact, discussing a policy or service guideline required some analysis of the parallel operational issues. Without understanding operational issues, the policy discussion could remain only guidance or at the worst, hypothetical. Hence, the discussions from the country assessments and the regional meeting fell into thematic findings regarding operational issues. Below are the ten primary findings on operational issues.

3.3.1 National Guidance on Training, Remuneration, and Types of Services Varies

Countries vary in their guidance and service delivery guidelines for CHWs. Some have a dual cadre system, such as Malawi, which has Health Surveillance Assistants (HSAs) as part of the paid health sector and Community Based Distribution Agents (CBDAs), who are totally volunteers. Others have a consolidated system with one cadre, such as the Village Health Workers in Uganda or the CHWs in Kenya. The training, remuneration, and types of services provided by the different cadres vary. Participants at the regional meeting thought that regional guidance for countries would be valuable, as a guide, not a prescriptive requirement. The guidance might address various levels of health cadres and refer to non-health groups such as teachers, police, youth peer educators, and military. Nomenclature may vary from country to country, but the service delivery package can provide guidance by the CHW roles.

3.3.2 Guidelines for Supervision of CHWs Vary

In addition to the overall variations in the cadres, length of training, and types of services provided, aspects of the health delivery systems vary extensively among the countries. A critical part of CHWs work, the assessments found, is supervision, including the type of training a supervisor has for this work. Often, supervisors are overworked themselves in district health clinics and do not make timely visits to the community level worker. Refreshers and updates from the supervisor are rare. For a CHW system to be sustainable, supervision needs to be addressed, according to the assessments and the regional meeting. The regional meeting noted that supervision guidelines and generic tools would be useful for ECSA member states. Supervision is an essential component of success, since those CHWs who receive regular supervision have been found to perform better than salaried CHWs who do not have regular supervision.

3.3.3 Information and Services from CHWs Need to Be Linked with Facilities

The need for good linkages arose in the field trip held during the regional meeting in Malawi. CBDAs in a village near Lilongwe, where the meeting was being held, described the problems they have regularly when referring clients to the nearest clinic. Clients are often either turned away, because the clinic is busy or simply won't accept the community clients, or they treat the clients poorly, discouraging follow-up visits. The regional meeting participants discussed the importance of linking CHWs with the nearest facilities during initial training, so that linkages are established in both directions, for the clinic to be aware of the CHWs and vice versa.

3.3.4 CHWs and Stakeholders Reported Problems with Motivation and Turnover

All countries reported issues related to sustainability, motivation, and remuneration of CHW. Regional guidelines would be valuable if they addressed possible approaches to remuneration, including in-kind services such as transport and maintenance, actual remuneration, and innovative approaches such as access to credit and community cooperatives and preferential treatment when they go for services. The options might be linked with the levels of cadres. There are other important issues that affect CHW motivations, including: involving community leaders, a possible career path for those who have the right qualifications, adequate supervision, availability of commodities, and refresher training.

3.3.5 Regular Supplies of Commodities Is a Problem

Systems that ensure a regular supply of commodities need improving in all countries participating in the assessment and dissemination workshop. Options could include community depots and monitoring systems, which require strong

community commitment. Countries should pay attention to the demand from the community, known as the "pull system" and not rely exclusively on a central quota system, known as the "push system." Member states need to ensure efficient use of the system and keep commodities that are up to date and safe.

3.3.6 Men Can be Barriers to FP Services in the Community

Respondents in all countries commented on the need to engage men more. This involved multiple ideas, including couple counseling by CHWs, using male CHWs, and working with village councils headed by men to develop community support. A model where CHWs go house to house can help to engage men through individual or couple discussions.

3.3.7 Youth Are a Large Portion of Potential Clients but Are Underserved

Community-based programs need to engage youth, including peer educators, youth centers, and other linkages with youth. Youth represent a large proportion of the rural population but are often underserved. There are many ways to engage youth, and all of them should be considered, given the large numbers of sexually active, unmarried youth and the need to provide good information on the benefits of FP to newly married youth.

3.3.8 Nurse/Midwives Organizations Want More Involvement in Community Services

There is a need to involve medical, nurses/midwives and their regulatory authorities and professional associations in training and supervising CHWs. Nurse/midwives can also provide the services at the community level, but this work should not be perceived as lower in the professional ladder.

3.3.9 CHW Activities with FP are Not Well Monitored

Community-based services need to be monitored and evaluated, especially as the types of service delivery strategies shift. Issues to consider include: dropout rates of lower level and unpaid CHWs; workload pressures of CHWs, especially when they are part of consolidated service systems (i.e., Kenya's new CHW strategy, Malawi's HSAs, and Uganda's Village Health Workers); new global and regional evidence on such issues as provision of injectables; and new research on motivation of CHWs.

3.3.10 Community Mobilization Is Important

Regional guidance on community mobilization approaches can assist member states in considering not only engagement of men and youth, but also such issues as community gatherings, contests, celebrations, and other educational events to highlight the benefits of family planning and the means of accessing services.

▼ 4.0 In Their Own Words

As part of the five country assessment, groups of CHWs participated in a focus group discussion in each country. The CHWs operate under different nomenclatures in their countries and provide a variety of services, depending on their training. In Uganda, CHWs have had several names depending upon the services they provide but are now being consolidated under Village Health Teams (VHTs). Malawi has two cadres, Health Surveillance Assistants (HSAs) and CBDAs. In Kenya, the nomenclature is in transition from CBD of family planning into CHWs, providing a broader range of services. In Lesotho, there are Community Based Distributors and Traditional Birth Attendants. In Zimbabwe, there are Community Based Distributors, Deport Holders, and Village Health Workers.

In all the countries, while the CHWs include both males and females, most of these workers are females. Some of the CHWs in the focus group discussions had been trained to provide Depo-Provera.

The summary below is a synthesis of the comments from the focus groups, as close to their words as possible, given that in a number of countries they talked through interpreters. These responses were translated from the local languages, and the remarks by individuals have been merged into one response for each question.

How do you view your role as a Community Health Worker?

The community was initially skeptical about FP due to misconceptions, but we have been able to sensitize people, particularly men, to the benefits of FP. Community members began seeing the positive outcomes of FP use. Although men continue to be a barrier to FP use and more sensitization is needed, we feel that our work is contributing to the development of our community. For example, our clients have more time to engage in productive activities because they have fewer children, and they are better able to provide for the children they do have. Our clients are also saving money they may have spent accessing services elsewhere. The money they may have used for transport or the loss of productive time they experienced traveling to health facilities is now less of a concern, as the services we provide are convenient and do not require travel.

What are the benefits of being a Community Health Worker?

The main benefit of being a CHW is our self-esteem, recognition, and sense of value we feel in our own community. We value the skills we have learned and the respect we feel within the community. Sometimes, even the facility personnel will refer clients to us because they are confident in the services we provide and are overloaded with work. We feel proud of our ability to dispel myths and misconception about FP, and community members feel comfortable approaching us with questions. Some of us were skeptical about FP at first too, but we have since come to realize the benefits. Other community members look to us as examples and are encouraged to use it as well.

How do you think the community can be more involved in delivering health services to women, men, and families?

Conducting sensitization at Local Council meetings could be a way to involve communities by using existing structures and systems. Dramas and music are also an effective way to harness community interest. We could create a women's group to sing, and this could mobilize a lot of people including community leaders. The sound of music will attract them to come and see what's going on.

What do you think about the supervision and training you received?

We receive monthly supervision visits by Save the Children field extension workers [Uganda], but sometimes they visit up to twice a week. We find the supervision visits motivating. We were trained to refer for any health issue that we were not taught to address. We have received two weeks of training on general FP, including pills and condoms,

plus an additional two weeks of training on Depo-Provera – one week on theory and one week practicum. We were also trained in issues of ante- and post-natal care, newborn care and nutrition, LAM, HIV, and STIs. We believe that our training adequately prepared us to perform our tasks, and welcome additional refresher trainings.

What are some of the challenges of being a community health worker?

Our workloads vary, but it is a concern for us because we are volunteers and need to engage in other income-generating activities. When our workloads are heavy, we do not have time have for other work. It is difficult volunteering our time and not being compensated. Also, the reimbursement for the transport cost to obtain re-supply is not sufficient. For those of us who have bicycles, any repairs are done at our own cost.

We also have challenges because of stock-outs. We are creating demand for FP but sometimes find there are no supplies at the facilities. As a result, we may disappoint our clients who are at risk of unintended pregnancy.

Completing referrals is another challenge. We have referral forms that we give to our clients to take to the health facility. At the facility, the health worker who sees the client will acknowledge it and the client is supposed to take it back to us. However, many clients lose their forms before they go to the facility.

What motivates you to perform your duties?

Overall, the love for our community motivates us to do this work. Despite our feeling that the compensation is inadequate, incentives such as bicycles and gumboots are motivating because they help us do our work better. In addition, having such items allows us to be recognized within our communities. We are also motivated by our relationship with Save the Children [Uganda], and our hope that better programs and incentives will be developed and that the future is promising.

5.0 Recommendations

The assessments and regional dissemination meeting showed that community-based FP has clear benefits in improving access to family planning information and services. Therefore, this approach is a powerful tool for social transformation towards improved quality of life at the community level, including improvement in the contraceptive prevalence rate and the resulting impact on maternal and child health. While promising practices and models are emerging, much remains to be done. Below are the major recommendations that emerged from this regional assessment. The recommendations track exactly the findings presented in section 3.0 of this report. For example, the five recommendations under section 5.1 track the first five findings in section 3.2 of the report.

5.1 Policies, Guidelines, and Strategies

- Include FP services explicitly as a priority in essential health packages, where CHWs are responsible for providing a wide range of services.
- Develop prototype policy and operational guidelines on issues related to the length of training, remuneration, and types of services to be provided by CHWs.
- Review country policies related to provision of contraceptive methods by CHWs, so that these policies are based on global and regional evidence.
- Address concerns expressed by regulatory and professional associations about CHWs.
- Conduct research including a needs assessment on options related to polities and guidance on pharmacists and drug shops as sources of contraceptives at the community level.

5.2 Financing

- Generate country specific ways to track financing of reproductive health, including FP, such as a national health account, subaccounts on RH, line item funding, or ring funding for FP.
- Develop a regional advocacy toolkit that countries can adopt and adapt to advocate for more FP funds.
- Develop ways that countries can gradually absorb FP programme costs, using such tools as costed implementation plans that include providing FP services at the community level.
- Where possible and not currently functioning, member states should establish a government agency with a mandate to focus on FP at the policy and financing level, similar to the ones of the national AIDS control programs.

5.3 Operational Issues

- Develop a regional service delivery package that provides discrete guidance on CHWs and FP. Such a package should define the roles of the health cadres as well as non-health groups such as teachers, police, youth peer educators, and military personnel.
- Develop supervision guidelines and generic tools that can be adapted by member states, including guidelines on proper training of CHW supervisors.
- Develop clear referral structures and linkages between the community and facilities (and vice versa), including linkages with maternal and child health systems.
- Address issues related to sustainability, motivation, and remuneration, including in-kind services such as transport, actual remuneration, possible career paths, refresher training and supervision, and innovative approaches such as access to credit and community cooperatives.

- Improve systems that can ensure continued supply of commodities to the CHWs, such as community depots and monitoring systems, both of which require strong community commitment. Countries should pay attention to the demand from the community, known as the "pull system" and not rely exclusively on a central quota system, known as the "push system."
- Strengthen efforts to engage men at the community level, including individual or couple discussions, having male CHWs, and engaging village councils and other forums that are often led by men.
- Engage unmarried, sexually active youth and newly married youth through peer educators, youth centers, and other linkages.
- Involve nurses/midwives and their regulatory authorities and professional associations in training and supervising CHWs, as well as providing services at the community level.
- Provide guidance on monitoring and evaluation of community-based FP including dropout rates of lower level and unpaid CHWs, work load pressures of CHWs, and new research on motivation of CHWs.
- Provide regional guidance on community mobilization approaches such as community gatherings, contests, and other events.

▼ 6.0 Conclusion

The assessments show that community-based FP has clear benefits in improving access to family planning information and services. Therefore, this approach is a powerful tool for social transformation towards improved quality of life at the community level, including improvement in the contraceptive prevalence rate and the resulting impact on maternal and child health. While promising practices and models are emerging, much remains to be done.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