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PROGRESS Approach
Institutionalizing Evidence-Based Practices

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PROGRESS Technical Meeting, Institutionalizing Evidence-Based Practices

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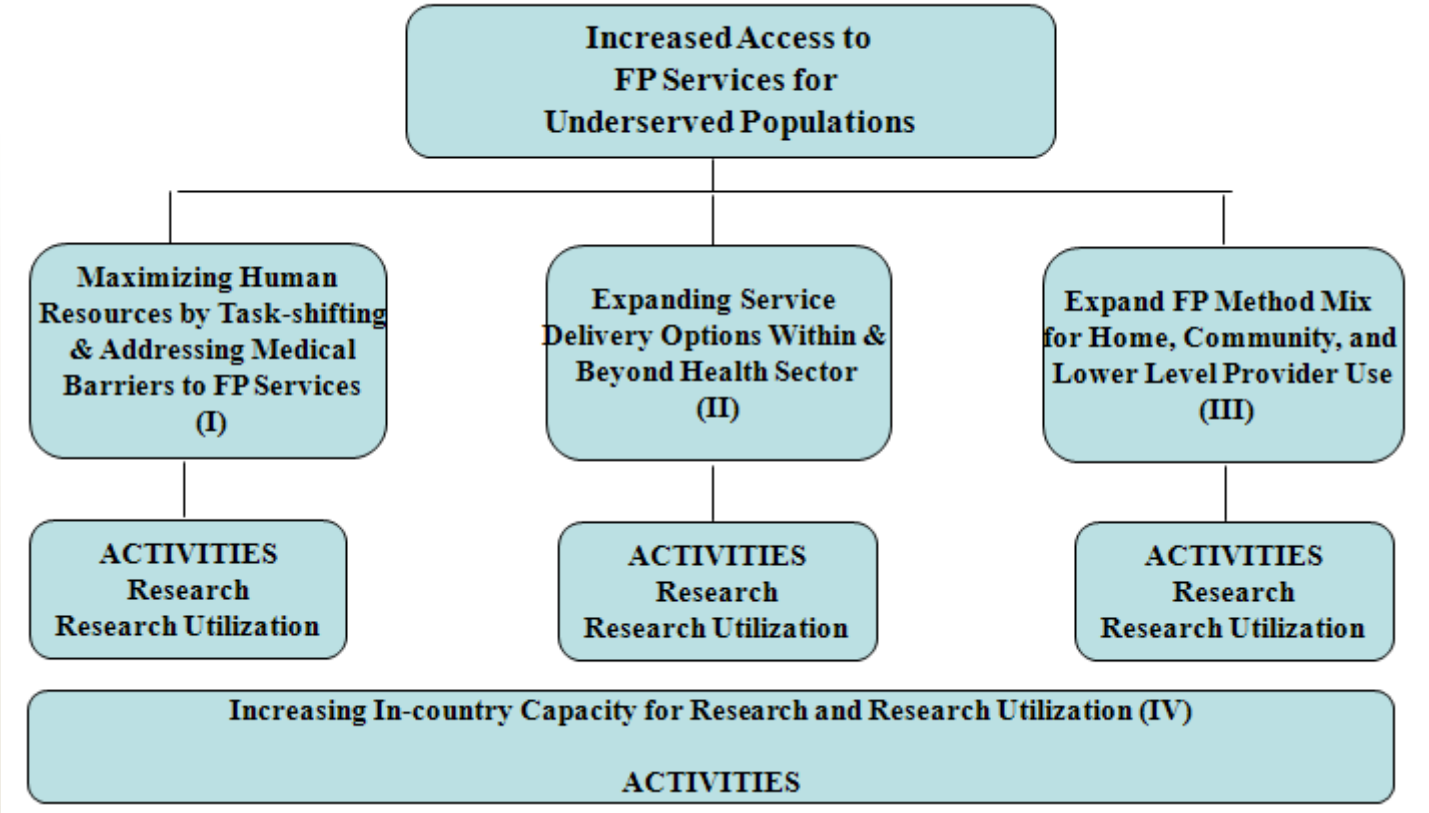
PROGRESS IN FAMILY PLANNING

The PROGRESS Framework



PROGRESS APPROACH

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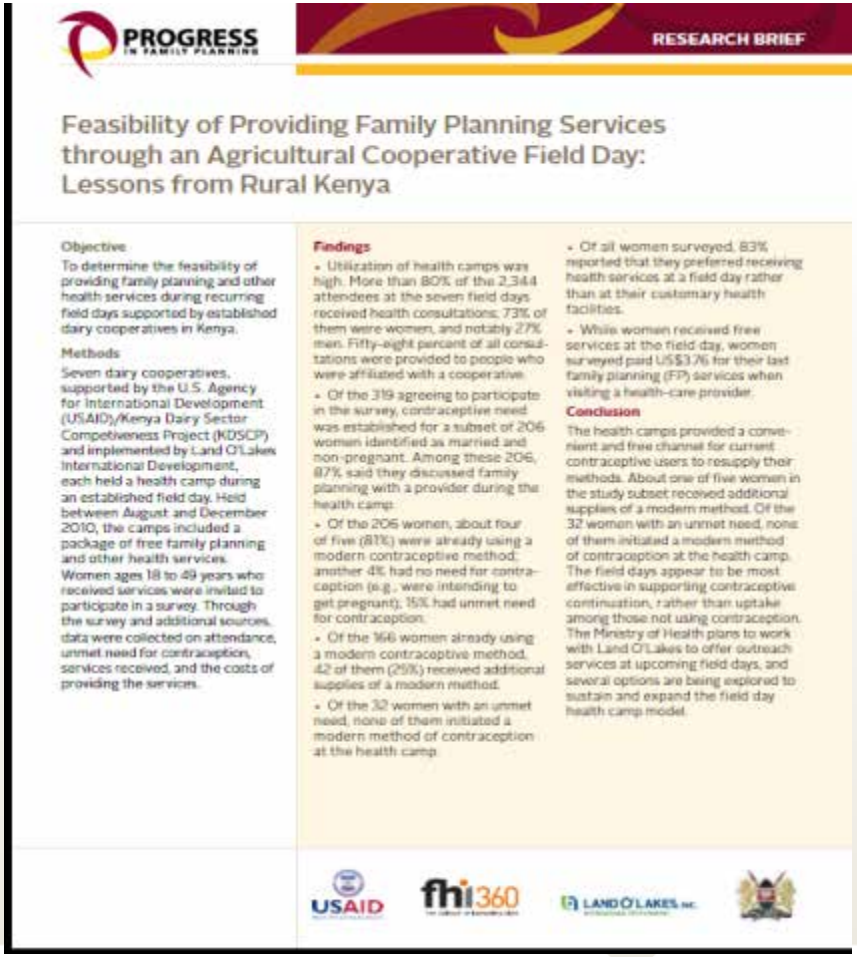
Generating, Strengthening, and Packaging Evidence

- As a research-project, PROGRESS focuses on generating, strengthening, and packaging evidence for a variety of audiences. The evidence cog is often the starting point in putting the other gears in motion.

Generating Evidence: Expanding Service Delivery Options – beyond the Health Sector

- A feasibility study with Land o'Lakes found that it was feasible to add FP/MCH services to field days
- More effective for resupplying methods rather than initiation
- Generated MOH interest in this outreach service



PROGRESS IN FAMILY PLANNING

RESEARCH BRIEF

Feasibility of Providing Family Planning Services through an Agricultural Cooperative Field Day: Lessons from Rural Kenya

Objective

To determine the feasibility of providing family planning and other health services during recurring field days supported by established dairy cooperatives in Kenya.

Methods

Seven dairy cooperatives, supported by the U.S. Agency for International Development (USAID)/Kenya Dairy Sector Competiveness Project (KDSCP) and implemented by Land O'Lakes International Development, each held a health camp during an established field day. Held between August and December 2010, the camps included a package of free family planning and other health services. Women ages 18 to 49 years who received services were invited to participate in a survey. Through the survey and additional sources, data were collected on attendance, unmet need for contraception, services received, and the costs of providing the services.

Findings

- Utilization of health camps was high. More than 80% of the 2,344 attendees at the seven field days received health consultations; 73% of them were women, and notably 27% men. Fifty-eight percent of all consultations were provided to people who were affiliated with a cooperative.
- Of the 319 agreeing to participate in the survey, contraceptive need was established for a subset of 206 women identified as married and non-pregnant. Among these 206, 87% said they discussed family planning with a provider during the health camp.
- Of the 206 women, about four of five (81%) were already using a modern contraceptive method; another 4% had no need for contraception (e.g., were intending to get pregnant); 15% had unmet need for contraception.
- Of the 166 women already using a modern contraceptive method, 42 of them (25%) received additional supplies of a modern method.
- Of the 32 women with an unmet need, none of them initiated a modern method of contraception at the health camp.
- Of all women surveyed, 83% reported that they preferred receiving health services at a field day rather than at their customary health facilities.
- While women received free services at the field day, women surveyed paid US$3.76 for their last family planning (FP) services when visiting a health-care provider.

Conclusion

The health camps provided a convenient and free channel for current contraceptive users to resupply their methods. About one of five women in the study subset received additional supplies of a modern method. Of the 32 women with an unmet need, none of them initiated a modern method of contraception at the health camp. The field days appear to be most effective in supporting contraceptive continuation, rather than uptake among those not using contraception. The Ministry of Health plans to work with Land O'Lakes to offer outreach services at upcoming field days, and several options are being explored to sustain and expand the field day health camp model.

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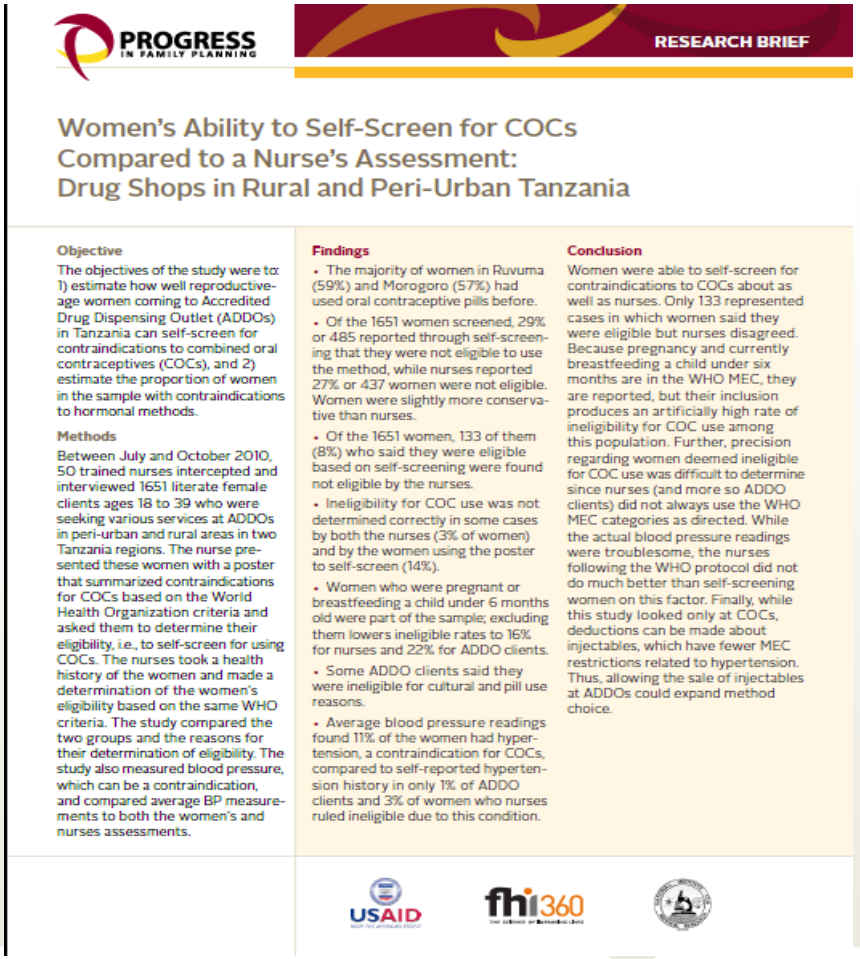
Generating Evidence: Exploring Options for Over the Counter Provision of Contraceptives

- Research among women using Accredited Drug Dispensing Outlets in Tanzania has shown women are able to self-screen for contraindications to COCs about as well as nurses.



PROGRESS IN FAMILY PLANNING

RESEARCH BRIEF

Women's Ability to Self-Screen for COCs Compared to a Nurse's Assessment: Drug Shops in Rural and Peri-Urban Tanzania

Objective

The objectives of the study were to: 1) estimate how well reproductive-age women coming to Accredited Drug Dispensing Outlet (ADDOs) in Tanzania can self-screen for contraindications to combined oral contraceptives (COCs), and 2) estimate the proportion of women in the sample with contraindications to hormonal methods.

Methods

Between July and October 2010, 50 trained nurses intercepted and interviewed 1651 literate female clients ages 18 to 39 who were seeking various services at ADDOs in peri-urban and rural areas in two Tanzania regions. The nurse presented these women with a poster that summarized contraindications for COCs based on the World Health Organization criteria and asked them to determine their eligibility, i.e., to self-screen for using COCs. The nurses took a health history of the women and made a determination of the women's eligibility based on the same WHO criteria. The study compared the two groups and the reasons for their determination of eligibility. The study also measured blood pressure, which can be a contraindication, and compared average BP measurements to both the women's and nurses assessments.

Findings

- The majority of women in Ruvuma (59%) and Morogoro (57%) had used oral contraceptive pills before.
- Of the 1651 women screened, 29% or 485 reported through self-screening that they were not eligible to use the method, while nurses reported 27% or 437 women were not eligible. Women were slightly more conservative than nurses.
- Of the 1651 women, 133 of them (8%) who said they were eligible based on self-screening were found not eligible by the nurses.
- Ineligibility for COC use was not determined correctly in some cases by both the nurses (3% of women) and by the women using the poster to self-screen (14%).
- Women who were pregnant or breastfeeding a child under 6 months old were part of the sample; excluding them lowers ineligible rates to 16% for nurses and 22% for ADDO clients.
- Some ADDO clients said they were ineligible for cultural and pill use reasons.
- Average blood pressure readings found 11% of the women had hypertension, a contraindication for COCs, compared to self-reported hypertension history in only 1% of ADDO clients and 3% of women who nurses ruled ineligible due to this condition.

Conclusion

Women were able to self-screen for contraindications to COCs about as well as nurses. Only 133 represented cases in which women said they were eligible but nurses disagreed. Because pregnancy and currently breastfeeding a child under six months are in the WHO MEC, they are reported, but their inclusion produces an artificially high rate of ineligibility for COC use among this population. Further, precision regarding women deemed ineligible for COC use was difficult to determine since nurses (and more so ADDO clients) did not always use the WHO MEC categories as directed. While the actual blood pressure readings were troublesome, the nurses following the WHO protocol did not do much better than self-screening women on this factor. Finally, while this study looked only at COCs, deductions can be made about injectables, which have fewer MEC restrictions related to hypertension. Thus, allowing the sale of injectables at ADDOs could expand method choice.

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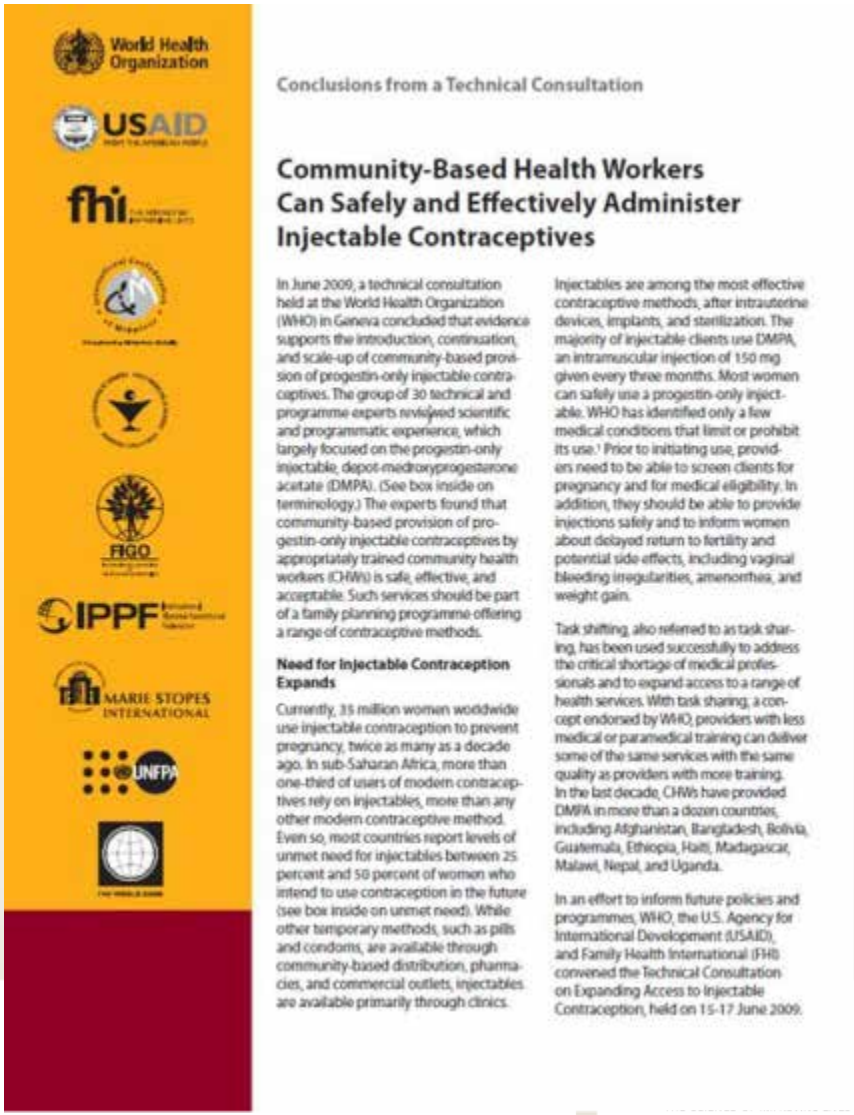
Synthesizing and Packaging Evidence: Expanding Access to Contraception from Community Health Workers

- WHO Technical Consultation, convened with WHO and USAID in 2009
- First global evidence review
- Findings establish community-based provision of injectable contraception as a global standard of practice



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IPPF
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UNFPA

Conclusions from a Technical Consultation

Community-Based Health Workers Can Safely and Effectively Administer Injectable Contraceptives

In June 2009, a technical consultation held at the World Health Organization (WHO) 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 programme experts reviewed scientific and programmatic experience, which largely focused on the progestin-only injectable, depot-medroxyprogesterone acetate (DMPA). (See box inside on terminology.) The experts found that community-based provision of progestin-only injectable contraceptives by appropriately trained community health workers (CHWs) is safe, effective, and acceptable. Such services should be part of a family planning programme offering a range of contraceptive methods.

Need for Injectable Contraception Expands

Currently, 35 million women worldwide use injectable contraception to prevent pregnancy, twice as many as a decade ago. In sub-Saharan Africa, more than one-third of users of modern contraceptives rely on injectables, more than any other modern contraceptive method. Even so, most countries report levels of unmet need for injectables between 25 percent and 50 percent of women who intend to use contraception in the future (see box inside on unmet need). While other temporary methods, such as pills and condoms, are available through community-based distribution, pharmacies, and commercial outlets, injectables are available primarily through clinics.

Injectables are among the most effective contraceptive methods, after intrauterine devices, implants, and sterilization. The majority of injectable clients use DMPA, an intramuscular injection of 150 mg given every three months. Most women can safely use a progestin-only injectable. WHO has identified only a few medical conditions that limit or prohibit its use.[1] Prior to initiating use, providers need to be able to screen clients for pregnancy and for medical eligibility. In addition, they should be able to provide injections safely and to inform women about delayed return to fertility and potential side effects, including vaginal bleeding irregularities, amenorrhea, and weight gain.

Task shifting, also referred to as task sharing, has been used successfully to address the critical shortage of medical professionals and to expand access to a range of health services. With task sharing, a concept endorsed by WHO, providers with less medical or paramedical training can deliver some of the same services with the same quality as providers with more training. In the last decade, CHWs have provided DMPA in more than a dozen countries, including Afghanistan, Bangladesh, Bolivia, Guatemala, Ethiopia, Haiti, Madagascar, Malawi, Nepal, and Uganda.

In an effort to inform future policies and programmes, WHO, the U.S. Agency for International Development (USAID), and Family Health International (FHI) convened the Technical Consultation on Expanding Access to Injectable Contraception, held on 15-17 June 2009.

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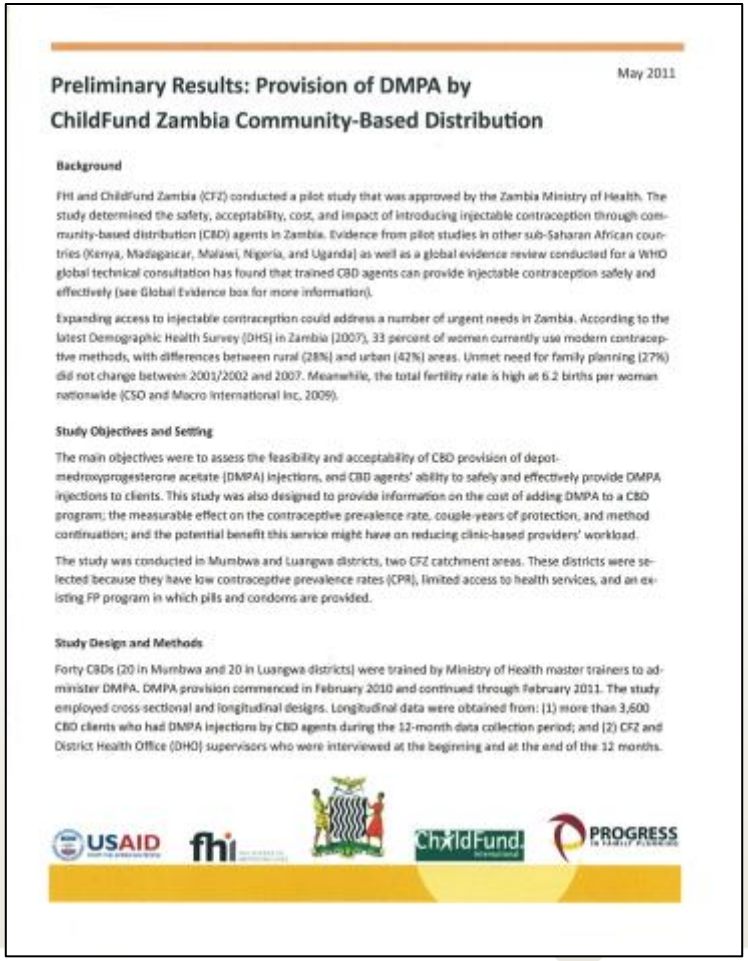
Ownership: Stakeholder Engagement, Champions, FPTWGs/Partners and Networks

- Ensuring stakeholders engagement in the whole research process
- Identifying, nurturing, and enabling champions
- Convening of global technical consultations
- Facilitating and participating in Family Planning Technical Working Groups
- Building local capacity to understand and utilize evidence

Ensuring Ownership: Pilot Studies in Partnership with Local MOH Investigators

- Zambia pilot generates evidence consistent with global evidence leading to MOH & stakeholder buy-in
- Evaluation of Malawi CBA2I program led to national scale up
- Kenya pilot informing advocacy efforts
- Senegal pilot underway



May 2011

Preliminary Results: Provision of DMPA by ChildFund Zambia Community-Based Distribution

Background

FHI and ChildFund Zambia (CFZ) conducted a pilot study that was approved by the Zambia Ministry of Health. The study determined the safety, acceptability, cost, and impact of introducing injectable contraception through community-based distribution (CBD) agents in Zambia. Evidence from pilot studies in other sub-Saharan African countries (Kenya, Madagascar, Malawi, Nigeria, and Uganda) as well as a global evidence review conducted for a WHO global technical consultation has found that trained CBD agents can provide injectable contraception safely and effectively (see Global Evidence box for more information).

Expanding access to injectable contraception could address a number of urgent needs in Zambia. According to the latest Demographic Health Survey (DHS) in Zambia (2007), 33 percent of women currently use modern contraceptive methods, with differences between rural (28%) and urban (42%) areas. Unmet need for family planning (27%) did not change between 2001/2002 and 2007. Meanwhile, the total fertility rate is high at 6.2 births per woman nationwide (CSO and Macro International Inc, 2009).

Study Objectives and Setting

The main objectives were to assess the feasibility and acceptability of CBD provision of depot-medroxyprogesterone acetate (DMPA) injections, and CBD agents' ability to safely and effectively provide DMPA injections to clients. This study was also designed to provide information on the cost of adding DMPA to a CBD program; the measurable effect on the contraceptive prevalence rate, couple-years of protection, and method continuation; and the potential benefit this service might have on reducing clinic-based providers' workload.

The study was conducted in Mumbwa and Luangwa districts, two CFZ catchment areas. These districts were selected because they have low contraceptive prevalence rates (CPR), limited access to health services, and an existing FP program in which pills and condoms are provided.

Study Design and Methods

Forty CBDs (20 in Mumbwa and 20 in Luangwa districts) were trained by Ministry of Health master trainers to administer DMPA. DMPA provision commenced in February 2010 and continued through February 2011. The study employed cross-sectional and longitudinal designs. Longitudinal data were obtained from: (1) more than 3,600 CBD clients who had DMPA injections by CBD agents during the 12-month data collection period; and (2) CFZ and District Health Office (DHO) supervisors who were interviewed at the beginning and at the end of the 12 months.

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Health Systems: Illustrative Elements including Policy, Training, Guidelines, Financing

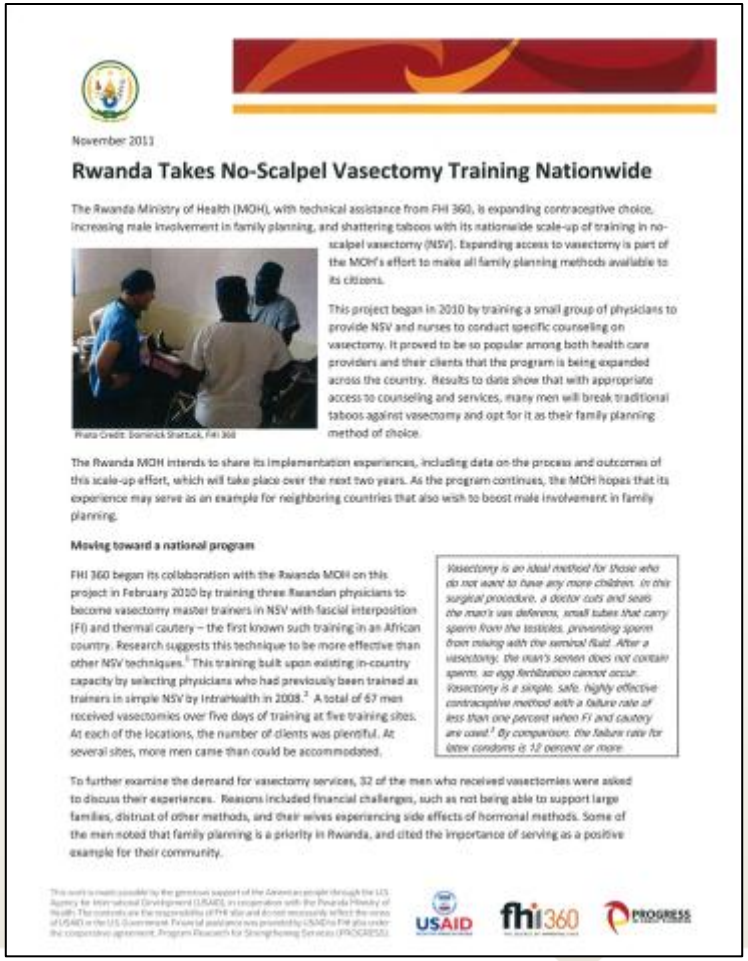
- PROGRESS designs and conducts research that addresses and informs the policy, training, and financial needs of health systems
- Works in partnership with country stakeholders to make evidence-based improvements to policies, systems, and structures
- Supports country programs to apply evidence in revising their service provider guidelines and training materials

Health Systems: Training, M&E, Financing, etc.

- Evidence to inform policy and programing - ECSA assessments to inform design and implementation of Community Based FP
- Toolkits to support implementation - CBA2I toolkit; FP Training Resource Package, the Invest FP calculator; IUCD checklist in India,
- Financing - Costing of interventions to inform scale up (Zambia CBA2I, Land o'Lakes & other non-health projects), and CIP in two countries
- Policy dialogue - CBA2I policies in Uganda, Kenya, Zambia, etc; National Leaders Conference in Kenya

Capacity Development and Strengthening Health Systems: Introduction and Scale up of Vasectomy Services

- Training physicians as master-trainers for vasectomy services
- Introduction of new simple techniques - NSV with fascial interposition and thermal cautery
- FHI and partners assisting MOH to scale up to all districts
- M&E plan developed to assess and monitor quality of services



November 2011

Rwanda Takes No-Scalpel Vasectomy Training Nationwide

The Rwanda Ministry of Health (MOH), with technical assistance from FHI 360, is expanding contraceptive choice, increasing male involvement in family planning, and shattering taboos with its nationwide scale-up of training in no-scalpel vasectomy (NSV). Expanding access to vasectomy is part of the MOH's effort to make all family planning methods available to its citizens.

Photo Credit: Dominick Shattuck, FHI 360

This project began in 2010 by training a small group of physicians to provide NSV and nurses to conduct specific counseling on vasectomy. It proved to be so popular among both health care providers and their clients that the program is being expanded across the country. Results to date show that with appropriate access to counseling and services, many men will break traditional taboos against vasectomy and opt for it as their family planning method of choice.

The Rwanda MOH intends to share its implementation experiences, including data on the process and outcomes of this scale-up effort, which will take place over the next two years. As the program continues, the MOH hopes that its experience may serve as an example for neighboring countries that also wish to boost male involvement in family planning.

Moving toward a national program

FHI 360 began its collaboration with the Rwanda MOH on this project in February 2010 by training three Rwandan physicians to become vasectomy master trainers in NSV with fascial interposition (FI) and thermal cautery – the first known such training in an African country. Research suggests this technique to be more effective than other NSV techniques.[1] This training built upon existing in-country capacity by selecting physicians who had previously been trained as trainers in simple NSV by IntraHealth in 2008.[2] A total of 67 men received vasectomies over five days of training at five training sites. At each of the locations, the number of clients was plentiful. At several sites, more men came than could be accommodated.

Vasectomy is an ideal method for those who do not want to have any more children. In this surgical procedure, a doctor cuts and seals the man's vas deferens, small tubes that carry sperm from the testicles, preventing sperm from mixing with the seminal fluid. After a vasectomy, the man's semen does not contain sperm, so egg fertilization cannot occur. Vasectomy is a simple, safe, highly effective contraceptive method with a failure rate of less than one percent when FI and cautery are used.[1] By comparison, the failure rate for latex condoms is 12 percent or more.

To further examine the demand for vasectomy services, 32 of the men who received vasectomies were asked to discuss their experiences. Reasons included financial challenges, such as not being able to support large families, distrust of other methods, and their wives experiencing side effects of hormonal methods. Some of the men noted that family planning is a priority in Rwanda, and cited the importance of serving as a positive example for their community.

This work is made possible by the generous support of the American people through the U.S. Agency for International Development (USAID), in cooperation with the Rwanda Ministry of Health. The contents are the responsibility of FHI 360 and do not necessarily reflect the views of USAID or the U.S. Government. Financial assistance was provided by USAID to FHI 360 under the cooperative agreement, Program Research for Strengthening Services (PROGRESS).

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Capacity Building: Keeping All of the Interlocking Systems Going Smoothly and Working Together

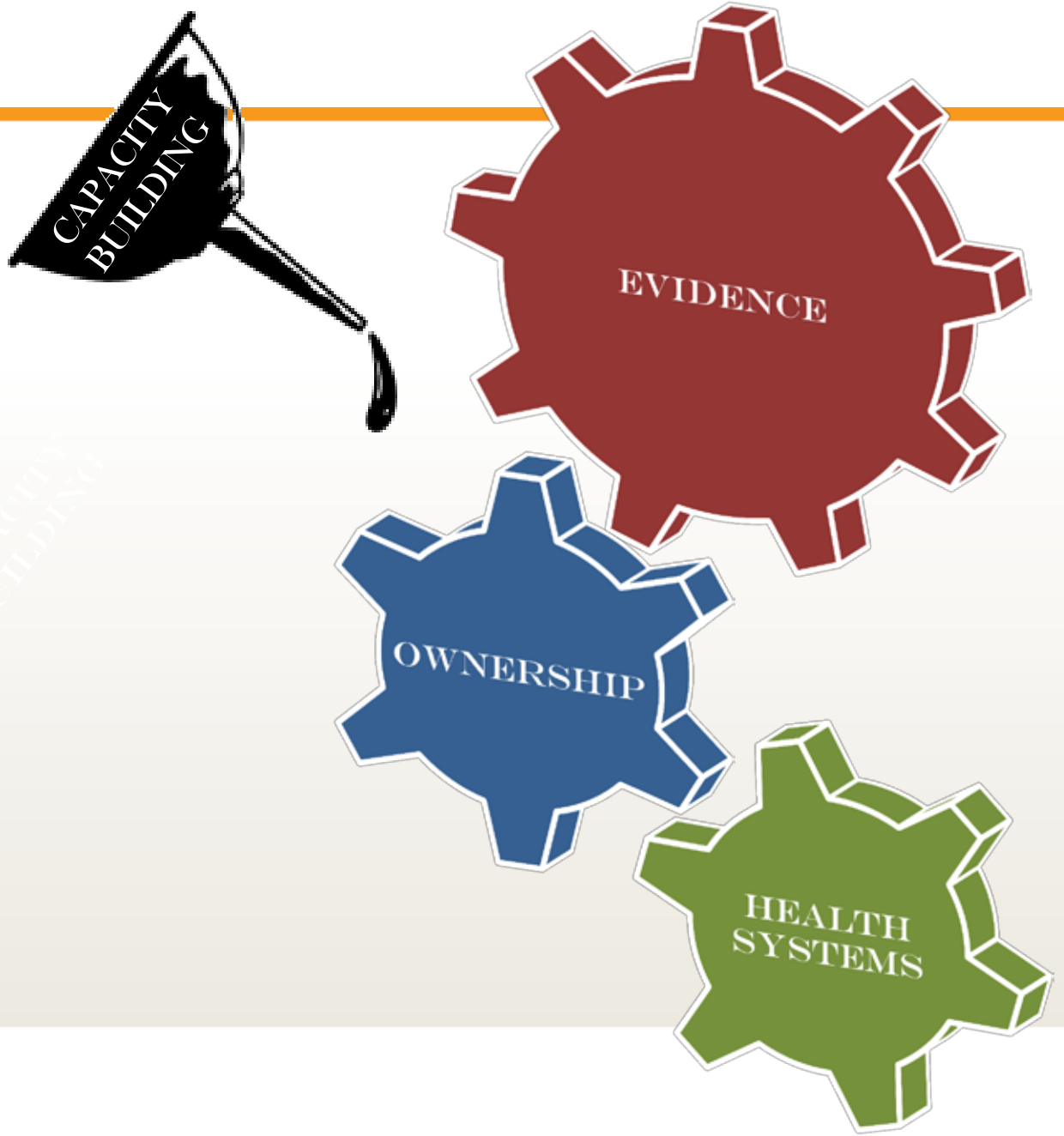
- As part of all of these efforts, PROGRESS seeks ways to build the capacity of local partners to identify research needs, to implement research studies, and to interpret and apply research results in order to improve programs and policies

Capacity Building: Illustrative Activities

- Non-health projects: training microfinance officers in Kenya and India; GBM community agents to integrate FP is making these systems stronger
- FPTWGs – supporting multiple task teams (mHealth in Kenya/Tanzania)
- Service provider guidelines , e.g., Tanzania, Ethiopia, Rwanda
- Large M&E project in Ethiopia – sustain/strengthen health system with M&E centers of excellence
- NIMR project in TZ – long-term, will help MOH
- LAPM training in Kenya

In Summary

- The PROGRESS approach applies this holistic approach to the entire research continuum. From the beginning of a new research study to the development of a policy based on a globally recognized evidence, PROGRESS supports local partners to identify and implement the steps needed to institutionalize evidence-based practices.



Global Technical Leadership (GTL): Promoting Knowledge, Taking Steps to Action

- Technical consultations
- Systematic reviews of evidence
- Creating evidence on mHealth innovations
- Using existing web technologies to highlight innovative integration approaches
- Working with key with partners:
  - Implementing Best Practices (IBP) Initiative
  - USAID High Impact Practices TAG
  - Africa Bureau
  - WHO research reviews, Cochrane reviews

GTL: Steps toward Expanding Access to Contraception from Community Health Workers

- WHO Technical Consultation, convened with WHO and USAID in 2009
- First global evidence review
- Findings establishes community-based provision of injectable contraception as a global standard of practice

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m4RH: Local Evidence Informs GTL Agenda

Initiation:

2008

USAID/PROGRESS

Research pilot

System:

Interactive SMS

Ping-pong

Opt-in

Countries:

Kenya

Tanzania

Women Deliver Award (2012): One of 50 Most Inspiring Ideas & Solutions for Girls & Women

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GTL: Compiling Programmatic Experience, Research Findings for FP-Immunization Integration

Experiences highlighted in an online map:

N=22:

§Bangladesh
§Burundi
§Ethiopia
§Ghana
§India
§Indonesia
§Kenya
§Liberia
§Madagascar
§Malawi
§Mali
§Nigeria
§Pakistan
§Philippines
§Rwanda
§Uganda
§Zambia

To view, go to www.fhi360.org/progress

Developed in partnership with MCHIP and members of the FP-Immunization Integration Working Group

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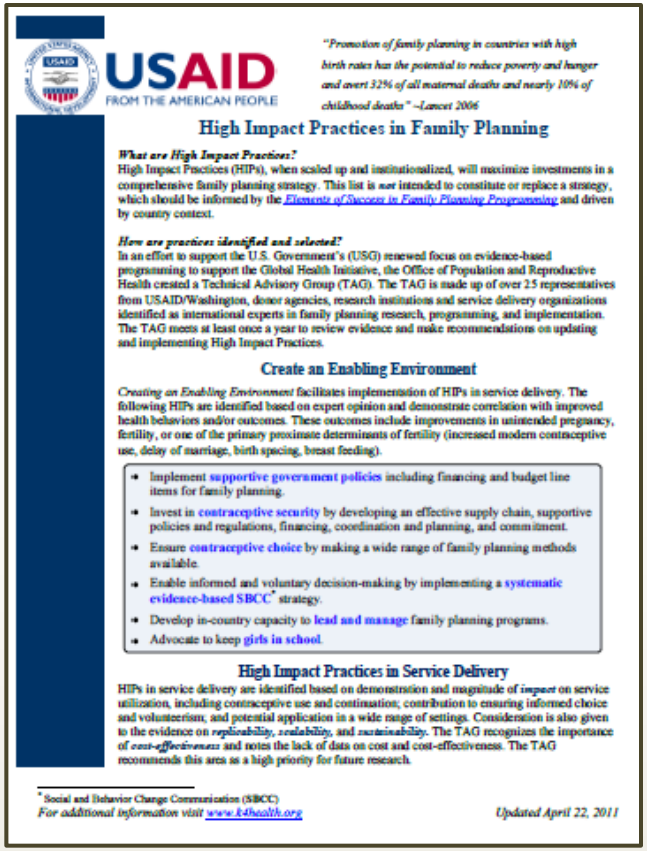
GTL: Innovative Approach Has Ripple Effects

- Collaboration with USAID and CAs to create similar maps for all the High Impact Practices (HIPs).
- Goal is to promote networking and south-to-south collaboration.
- One combined map will be created and posted on K4Health.
- Maps are currently being developed for the following topics:
  - FP-Immunization Integration
  - Post abortion care
  - Mobile services
  - Provision of FP by community health workers (CHWs)



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"Promotion of family planning in countries with high birth rates has the potential to reduce poverty and hunger and avert 32% of all maternal deaths and nearly 10% of childhood deaths" –Lancet 2006

High Impact Practices in Family Planning

What are High Impact Practices?
High Impact Practices (HIPs), when scaled up and institutionalized, will maximize investments in a comprehensive family planning strategy. This list is *not* intended to constitute or replace a strategy, which should be informed by the *Elements of Success in Family Planning Programming* and driven by country context.

How are practices identified and selected?
In an effort to support the U.S. Government's (USG) renewed focus on evidence-based programming to support the Global Health Initiative, the Office of Population and Reproductive Health created a Technical Advisory Group (TAG). The TAG is made up of over 25 representatives from USAID/Washington, donor agencies, research institutions and service delivery organizations identified as international experts in family planning research, programming, and implementation. The TAG meets at least once a year to review evidence and make recommendations on updating and implementing High Impact Practices.

Create an Enabling Environment

Creating an Enabling Environment facilitates implementation of HIPs in service delivery. The following HIPs are identified based on expert opinion and demonstrate correlation with improved health behaviors and/or outcomes. These outcomes include improvements in unintended pregnancy, fertility, or one of the primary proximate determinants of fertility (increased modern contraceptive use, delay of marriage, birth spacing, breast feeding).

- Implement **supportive government policies** including financing and budget line items for family planning.
- Invest in **contraceptive security** by developing an effective supply chain, supportive policies and regulations, financing, coordination and planning, and commitment.
- Ensure **contraceptive choice** by making a wide range of family planning methods available.
- Enable informed and voluntary decision-making by implementing a **systematic evidence-based SBCC*** strategy.
- Develop in-country capacity to **lead and manage** family planning programs.
- Advocate to keep **girls in school**.

High Impact Practices in Service Delivery

HIPs in service delivery are identified based on demonstration and magnitude of *impact* on service utilization, including contraceptive use and continuation; contribution to ensuring informed choice and volunteerism; and potential application in a wide range of settings. Consideration is also given to the evidence on *replicability*, *scalability*, and *sustainability*. The TAG recognizes the importance of *cost-effectiveness* and notes the lack of data on cost and cost-effectiveness. The TAG recommends this area as a high priority for future research.

* Social and Behavior Change Communication (SBCC)
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Updated April 22, 2011

Please take the survey:
http://www.k4health.org/hips/map-survey

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