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COMMUNITY-BASED ACCESS TO INJECTABLES: AN ADVOCACY GUIDE

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EXECUTIVE SUMMARY

Injectable contraceptives are popular among women, especially in sub-Saharan Africa. Health officials and providers in a growing number of countries seek to make injectable contraceptives more widely available at the community level through trained paraprofessionals. Studies and field observations have found that community health workers (CHWs) can provide injectables safely and that community access to injectables attracts new contraceptive users.

This guide is designed to assist the many health professionals and advocates who are interested in making injectable contraceptives more widely available, especially for women with little or no access to health facilities. It will also be useful to donors, family planning/reproductive health professionals, and others who may not be directly involved in advocacy but need to understand the process and the rationale for community access to injectable contraceptives.

The guide describes six steps that advocates can take to support policy change to permit CHWs to provide injectables:

1. Form a working group and assess feasibility
2. Collect data and information
3. Plan your strategy
4. Develop advocacy messages and talking points
5. Plan to monitor and evaluate progress
6. Implement the advocacy plan

In most countries, the decision to change health service delivery guidelines is the responsibility of the Ministry of Health (MOH), with advice from professional societies that set medical standards and the drug regulatory authority. Accordingly, advocacy work regarding injectables often consists of informing health professionals, engaging them in dialogue, explaining the importance of community provision, and showing them that it can work. The process is likely to evolve to include new tasks, such as reaching out to additional stakeholders, recruiting policy champions, initiating a demonstration project, and organizing site visits.

Based on experiences in several countries, this guide emphasizes the need to analyze the local setting and policy climate carefully, to focus advocacy work on the key decisionmakers and influential stakeholders, and to be patient and persistent in addressing challenges and delays. At the same time, advocates must be flexible to adapt to changes in the policy environment, such as turnover in key MOH personnel, a new controversy that becomes a topic of public debate, statements by politicians and opinion leaders, and changes in government priorities. When a new opportunity arises, advocates have to be prepared to move quickly to take advantage of the situation.

With its focus on advocacy and policy change, this guide is designed to complement the comprehensive reference materials available to lead program managers and health providers through the implementation process. Implementation of community-based access to injectables begins with determining the feasibility and need for such services and then proceeds to setting them up, including establishing service delivery guidelines, identifying and training community-based distributors, creating supervision and logistics systems, and providing community education (Weil et al., 2008; see also http://www.k4health.org/toolkits/communitybasedfp/cba_injectables).

ABBREVIATIONS

CBA	community-based access
CBD	community-based distribution
CHW	community health worker
CPR	contraceptive prevalence rate
DMPA	depot-medroxyprogesterone acetate
FHI	Family Health International
FP	family planning
M&E	monitoring and evaluation
MOH	Ministry of Health
MP	member of Parliament
NGO	nongovernmental organization
RH	reproductive health
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

INTRODUCTION

Injectables rank among the most popular contraceptive methods worldwide, and in sub-Saharan Africa, they are the leading method (Lande and Richey, 2006). Clinical studies attest to their safety and efficacy. However, in many countries, access to injectables is limited by policies and guidelines that require them to be provided by physicians and nurses. This requirement would pose no difficulty if most people had access to clinical services staffed with the necessary number of medical professionals. Unfortunately, far too many people—especially those who live in rural, remote areas, those in the lowest wealth quintiles, and other marginalized groups—have little or no access to such facilities.

Many countries are grappling with securing an adequate number of health professionals who not only have the requisite technical expertise and training but also are distributed throughout the country to meet the entire population's healthcare needs. Every country has groups of people and geographic areas that lack adequate access to clinical care. Sub-Saharan Africa, in particular, is experiencing an acute shortage of health professionals, and this shortage is expected to continue due to increases in population size, insufficient numbers of trained health providers, emigration, career changes (often due to poor working conditions), premature death, and other causes (Kinfu et al., 2009). Some countries are exploring ways to reduce the heavy workload of doctors, nurses, and midwives by allocating some of their tasks to less specialized health workers (WHO, 2007). This process of delegating, sharing, or shifting tasks requires careful planning and adequate training and supervision to ensure that the standard of care is maintained.

In most settings, offering injectables at the community level leads to a sharp rise in contraceptive prevalence (Lande and Richey, 2006), thus reducing unmet need for family planning and avoiding the health risks associated with pregnancy and childbirth. In sub-Saharan Africa, injectables have been a major factor in increases in contraceptive prevalence, since they have attracted new contraceptive users rather than shifting users from other contraceptive methods (see Appendix B).

At a 2009 meeting of international experts hosted by the World Health Organization (WHO), the group reviewed existing research studies on the safety, effectiveness, and acceptability of community-based provision of injectable contraceptives and concluded that injectables can be provided safely at the community level by appropriately trained community health workers. Ten international agencies, including international federations of medical professionals, have endorsed their conclusions (see Box 1).

Several countries in sub-Saharan Africa have begun to provide injectable contraceptives at the community level, using specially trained and supervised community health workers. These programs have been set up to compensate for the lack of health services in many areas and the shortage of health providers. The first countries in Africa to permit paramedical providers to administer injectables are Ethiopia, Madagascar, Malawi, Rwanda, and Uganda. Health officials and providers in other African countries are taking steps to introduce this approach.

With a focus on advocacy and policy change, this guide is designed to assist the many health professionals and advocates interested in making injectable contraceptives more widely available. It will also be useful to donors, family planning/reproductive health professionals, and others who may not be directly involved in advocacy but need to understand the process and the rationale for community access to injectable contraceptives.

The guide is designed to complement the comprehensive reference materials available to lead program managers and health providers through the process of determining the feasibility and need for community-based access to injectables and the steps to setting up such services, including establishing service delivery guidelines, identifying and training community-based distributors, creating supervision and logistics systems, and providing community education (see Weil et al., 2008; see also http://www.k4health.org/toolkits/communitybasedfp/cba_injectables).

Box 1. International Consensus on Community-based Access to Injectables

"Sufficient evidence exists for national policies to support the introduction, continuation, and scale-up of community-based provision of progestin-only injectable contraceptives, especially DMPA."

—World Health Organization, U.S. Agency for International Development, and Family Health International. 2009. *Community-Based Health Workers Can Safely and Effectively Administer Injectable Contraceptives*. p. 3. Accessed at: http://www.who.int/reproductivehealth/publications/family_planning/WHO_CBD_brief.pdf

This statement has been endorsed by 10 international agencies, including the International Federation of Gynecology and Obstetrics, International Council of Nurses, and the International Confederation of Midwives.

WHO, USAID, and Family Health International have summarized the rationale for community-based access to injectables:

- Community health worker provision of injectable contraceptives expands access to family planning options in developing countries.
- Many women prefer injectable contraceptives over other family planning methods.
- Community health workers can bridge the gap between the large number of clients and an insufficient number of professional healthcare workers in developing countries. The lack of healthcare workers is especially acute in hard-to-reach and rural areas.
- Given appropriate training, community health workers can safely and effectively screen clients, provide injectable contraceptives, counsel on side effects, and demonstrate skills that are equal to facility-based providers.
- Overwhelmingly, clients express satisfaction with injections by community health workers, and community health workers express comfort in providing the injection.
- Increasingly, developing countries are supporting the introduction and scale-up of programs that allow community health workers to provide injectable contraceptives.

ADVANCING ENABLING POLICIES

Policies—laws, regulations, service delivery protocols, and proclamations—are the foundation for health programs. They often reflect program priorities, professional standards, societal values, and budgetary realities. Pressure to change policies arises when new technologies, systems, and ideas are introduced. Resistance to change is built into the system because policies are intended to be stable and durable.

Provision of injectable contraceptives by community health workers represents a change in the status quo that requires a re-examination of medical standards, assumptions about the ability of less specialized health workers to provide this method safely, and even attitudes toward women's use of contraception. Hence, such a proposed change sparks controversy and elicits strong opinions. As with many innovations, it takes time to gain a consensus to try a new approach. The various people involved in deciding health policy and service delivery guidelines often have concerns and questions. It is important to engage all decisionmakers, including those who are resistant to the idea, in dialogue and provide the evidence needed to support a change in the current system and address any misinformation or misconceptions.

The overall objective of advocacy for community-based access to injectable contraceptives is usually to change service delivery guidelines to allow trained paraprofessionals to provide injectables. The service delivery guidelines are usually set by the Ministry of Health (MOH) in consultation with agencies that establish standards for provision of medical services and the drug regulatory authority. Changing service delivery guidelines can be challenging because of the veto power held by key individuals and agencies. Also, the key decisionmakers are often influenced by various people—political leaders, medical associations, colleagues, friends, and relatives—who may hold strong views without necessarily understanding the facts.

In most settings, the advocacy process evolves as opportunities are identified. Some typical tasks are (1) raising the issue with key decisionmakers, understanding their concerns, providing information to address their concerns, and engaging them in dialogue; (2) broadening the dialogue to include key professionals who influence the decisionmakers; (3) raising awareness of the issue; (4) educating the general public—specifically reproductive-age women—on the benefits of community access to injectables; (5) countering misinformation; (6) identifying and orienting champions; (7) setting up a demonstration project; and (8) collaborating with a team charged with drafting revisions to existing service delivery guidelines. Advocating for changes in policy is a cyclical process, requiring adjustments to cope with false starts, advances, and setbacks.

The advocacy process does not end when the policy is adopted. Advocates need to ensure that a viable plan is developed and funds are allocated to put the new change into practice, the necessary personnel are recruited and trained, and systems to ensure appropriate provision of services are operational. The process of supporting implementation is discussed in detail in the report, *Taking the Pulse of Policy* (Bhuyan et al., 2010).

THE SIX STEPS FOR ADVOCACY FOR COMMUNITY ACCESS TO INJECTABLES

This section aims to provide practical guidance to health professionals and advocates who are interested in making injectable contraceptives more widely available. It suggests actions that advocates can take to build support for community access to injectables. These steps are drawn from several advocacy guides (POLICY project, 1999; POLICY project, 2005; USAID | Health Policy Initiative, 2007b; WHO Regional Office for Africa and USAID, 2008) and adapted for this specific topic.

The six steps are:

1. Form a working group and assess feasibility
2. Collect data and information
3. Plan your strategy
4. Develop advocacy messages and talking points
5. Plan to monitor and evaluate progress
6. Implement the advocacy plan

Step 1. Form a Working Group and Assess Feasibility

Form a small working group including individuals interested in learning about the provision of injectable contraceptives by community health workers. Group members should be willing to collect some basic information and data to determine whether this practice will improve delivery of family planning services. It is highly advisable to identify an MOH official to participate in the working group because working with the ministry is essential in obtaining approval for community provision of injectables. The working group would also benefit from the expertise of a health professional currently providing FP services. It would also be useful to talk with some community workers and traditional health providers to gain their perspective. The working group could be a subcommittee of an existing group that oversees family planning/reproductive health policies and services.

Initially, the group should cover some basic factors related to the feasibility and need for community access to injectables:

- Based on the most recent Demographic and Health Survey (if available) or other data, what proportion of women using contraceptives are using injectables? Is this a preferred contraceptive method? Is there a difference between use by urban and rural women? If so, could this difference be equalized if the contraceptives and providers were available?
- What are the parameters of the current service delivery guidelines regarding the providers of injectable contraceptives? What changes are needed to service delivery guidelines to allow community access to injectables? Who is involved in approving revisions to relevant guidelines and policies?
- Are there areas of the country where people other than doctors and nurses provide injections—for child immunization or treatment of other illnesses? Are there any anecdotal reports of injectable contraceptives being provided by nonmedical persons?
- Are there appropriate cadres of health providers with extensive national coverage who could be considered to provide injectable contraceptives in underserved areas? Could drug shop owners or pharmacists be used to administer injectables?

The answers to these questions may give some indication regarding the need for community services and the complexity of setting up such services. For more details on determining the feasibility and need for community access to injectables, see Weil et al., 2008, p. 7–8.

Discuss the findings of your initial information gathering among the working group. Is there a case for making injectables more widely available? Are there existing cadres of community workers who could be trained to provide injectables? Note that an appropriate cadre of community workers must be in place before plans to provide injectables at the community level can go forward. Creating such a cadre for this sole purpose is impractical, given the many competing demands for health resources.

Step 2. Collect Data and Information

If the initial assessment seems promising, expand the information collection process and assign individuals and organizations to take responsibility for specific topics. At this point, it might be advantageous to increase the size of the working group to support this expanded effort. A broader array of advocates and potential champions would be useful in setting priorities, developing messages, and contacting key people and organizations.

The working group should collect information from many sources to understand the decisionmaking process, the views of various stakeholders on community provision of injectables, and the perspectives of potential beneficiaries. This information can be used in developing the advocacy plan as well as specific advocacy messages.

Group members should collect available data from government health reports; surveys such as the most recent Demographic and Health Survey; and other studies on injectable use, unmet need for family planning, and women's attitudes toward injectables. In addition, group members should conduct interviews with key people likely to be decisionmakers or wield influence in the process. Alternatively, group members could interview key informants knowledgeable about the views of these decisionmakers. The group should collect information on (1) the views of health providers on injectables and their provision by paramedical personnel; (2) views of reproductive-age women living in rural areas regarding their preferred contraceptive methods and sources; and (3) views of community leaders. This research need not be extensive, but it should provide useful information on community needs and preferences. Group members should also make observational visits to areas with limited access to health services so they can describe their observations first hand.

See Box 2 for suggestions regarding information to be collected. While this list duplicates some items covered in Step 1, the intent is to cover them more in depth, once the decision to proceed further has been made. A checklist that could be adapted to the questions in Box 2 is contained in Weil et al., 2008, Appendix 4, p. 61–64.

Box 2. Suggestions for Data and Information Collection

Following are some sample questions that can be part of the in-depth data and information collection process in Step 2. The working group can decide which ones are relevant in the context of the country setting.

- **Is there consumer demand for injectables?** What proportion of women using contraceptive methods are using injectables? What proportion of women surveyed state that they plan to use injectables in the future? What are consumers' views or concerns about injectables?
- **Is there a need for community provision of injectables?** What are the existing sources of injectables (public health facilities, private medical providers, pharmacies, non-licensed providers)? Are there any existing sources of injectables at the community level that could serve as an example or be set up as a demonstration project? What social marketing programs are selling injectables? Who gives these injections?
- **Is there a shortage of health workers in certain areas?** How many health providers are there in various specialties? What is the distribution of health workers by district? How many health workers are there per 100,000 people in each district? How many clinics and health posts are there, and where are they located? Is there a current or expected shortage of health workers overall or a shortage of health workers in specific areas (e.g. rural or remote areas)?
- **Who would provide injectables at the community level?** Are there existing community-based programs? What cadres of community workers are involved in those programs? Could these cadres be trained to give injections? Can these workers be linked to existing clinics for supervision, supplies, and referral in case of complications? Are there cadres of workers who already provide child immunizations? Are community workers regularly employed, or are volunteers given incentives? Is there high turnover among these workers? What is the education level of these workers and length of the current training program?
- **What are the current government policies and guidelines regarding injectable contraceptives and community-based distribution of contraceptives in general?** Review national health policy and service delivery guidelines. What types of health workers are permitted to give injections? Do current guidelines require family planning (FP) clients of community workers to receive a facility-based clinical assessment before the community workers can provide or continue to provide FP methods such as oral contraceptives?
- **What process is needed to change the current policies and guidelines regarding community access to injectables?** Can the Minister of Health approve the new guidelines? What other individuals and agencies are likely to be consulted? Who are the decisionmakers? What is their influence or power? How do they relate to each other? Are there specific times when decisions regarding changes in service delivery guidelines are made, or is it as the occasion arises?
- **What are the prevailing opinions and attitudes regarding the acceptability and feasibility of community provision of injectables among key FP stakeholders?** Is this a new concept or a continuing debate? Is the FP community supportive of this idea?
- **What information is available regarding the safety and effectiveness of provision of injectables by community health workers?** Are there examples from your country or a neighboring country?
- **What public-private partnerships could be beneficial to community provision of injectables?** Would private providers be interested in providing injectables? Could they collaborate with the MOH to provide affordable services to low-income groups?

Step 3. Plan Your Strategy

Based on the findings from your data and information collection, discuss the opportunities and barriers identified. Reach consensus on a strategy for the working group to pursue. The strategy should be based on the likely decision points and key decisionmakers. For example, if the decision regarding community provision of injectables will be made by MOH officials, it would be important to interview them (or knowledgeable insiders) to understand where they stand on this issue. Meet with MOH officials responsible for reproductive health, government officials responsible for health service quality standards, and leaders of professional organizations for health providers. Take careful account of their concerns and reservations and plan your strategy, activities, and messages to address them.

Setting the overall objective. The objective should be clearly defined and achievable within a concrete timeframe. An example of an overall objective is to "achieve adoption of national service delivery guidelines allowing for community provision of injectables, including an implementation plan and allocation of funds." Working group members may want to set a narrower objective or intermediate results, since this objective could take a long time to achieve because it may require a series of actions. Examples of such actions are

- Creating an enabling environment by informing decisionmakers on community access to injectables;
- Having a dialogue with key decisionmakers to understand and address their views;
- Working with managers to lay out the necessary steps needed to adopt and implement a new policy and/or service delivery guidelines;
- Setting up a demonstration project;
- Conducting an observation visit of the demonstration project site or a study tour to a country with community access to injectables;
- Drafting service delivery guidelines; and
- Achieving adoption and implementation of the guidelines nationwide.

These steps could be used as markers of progress, although they may not occur in a standard sequence or a predictable timeframe.

Selecting the target audiences. Based on your overall strategy, the working group should map out the decisionmaking points and identify the key individuals who will make or have a major influence on the decisions. This key group is likely to include MOH officials, health regulatory bodies, and leaders of associations that set professional medical standards, Typically, advocates will work with these decisionmakers and "influencers" first—mostly through individual and small-group meetings. For example, a working group member may talk one-on-one with key contacts initially. Then the working group could organize a presentation and small discussion among 3–4 people in the same work unit.

During this process, the working group will identify additional stakeholders such as district health officers, leaders of medical training institutions, and other individuals considered essential to the decisionmaking process. This first-tier of decisionmakers and influencers could be the primary target audience:

- MOH officials, especially those working in reproductive health and community health
- Members of decentralized MOH teams, especially district health officers
- Leaders of professional associations for health workers, especially doctors, nurses, and midwives
- Leaders of health regulatory bodies, including medical, nursing, and pharmacy boards
- Leaders of higher education institutions that train doctors, nurses, and midwives

The working group should identify specific individuals and give them personal attention, rather than trying to reach many people. Attempting to cover too many people and groups will dilute the overall effect.

As the advocacy effort progresses, the working group may expand its reach to selected individuals from other groups that may contribute to the decisionmaking process or be the main implementers of the new services. These individuals and groups could be considered possible secondary target audiences:

- Public and private sector health workers at national, regional, and district levels
- Other officials working on community development, gender, and social welfare
- Staff from training facilities for health workers
- Representatives of nongovernmental organizations—service providers, advocacy groups, and women's groups
- Representatives of donor agencies
- Pharmacists and licensed dispensers of pharmacy products
- Pharmaceutical distributors and wholesalers
- Health researchers
- District and community leaders
- Current and potential FP clients
- Representatives of donor agencies

These stakeholder groups can be further refined. For example, working group members may think that women professionals and community leaders might be especially interested in this issue.

The selection of target audiences will depend on the type of cadre of health workers identified as potential providers of injectables. For example, different strategies would be needed for community health workers who are government employees, NGO volunteers, village health committees, or pharmacists.

Anticipating and overcoming barriers. The working group will need to decide, based on unique country circumstances, which advocacy strategies are most suited to addressing the concerns and possible opposition from key decisionmakers. Clearly, working group members cannot address all the issues raised by stakeholders. By understanding the policy process, group members can formulate an appropriate strategy to focus on key target audiences and advocacy messages. To avoid raising the profile of the issue and inciting a backlash, it is important to proceed slowly and carefully to sound out key decisionmakers and discuss their concerns. One-on-one meetings may help to exchange views without causing undue rancor.

Stakeholder concerns should be addressed with sensitivity and respect. Messages with accurate information provided by credible spokespersons can help allay irrational fears. Recognize that concerns about the competence of community workers are legitimate. It may help to involve key stakeholders with such concerns in the design of community worker selection, training, and supervision protocols to ensure adequate safeguards.

Concerns of health officials and providers. Typical concerns of health officials and providers are (1) possible side effects of injectables; (2) safety of the provision of injectables by non-medical personnel due to their lower degree of training and potential problems such as inadequate supervision and failure to detect contraindications to injectables; (3) possible loss of status if they relinquish their role to non-medical personnel; (4) loss of personal or clinic income derived from client payments; (5) loss of respect from their peers if they are perceived as downplaying safety standards; (6) risk of criticism (and perhaps legal liability) if instances of poor care arise; (7) opening the way to use of illicit drugs due to availability of syringes and trained injectionists; and (8) assertions that they are condoning sexual relations outside of marriage, fomenting promiscuity, and increasing the risk of HIV transmission.

Concerns of professional medical groups. Leaders of medical societies and professional organizations for doctors, nurses, and midwives are responsible for setting standards for care. Accordingly, they have some of the same concerns as health officials and providers regarding client safety, quality of care, and professional status. They may be especially resistant to any changes in current service delivery guidelines.

Possible activities to address the concerns of health professionals are to (1) hold individual or small group meetings with respected medical experts to address concerns about safety; (2) share a policy memo that summarizes research findings related to stakeholders' key concerns; (3) conduct field research to document local conditions, access to FP and other health services, consumer preferences, and existing practices regarding injectable contraceptives; (4) enlist the help of medical professionals who see the benefits of community provision and ask them to talk with their peers; (5) seek agreement to introduce a well-monitored demonstration project; (6) provide data and examples from other countries that have successfully implemented community access to injectables; (7) hold a meeting for stakeholders to present relevant data and information on community access to injectables; (8) organize a study tour to countries that have programs with community access to injectables; (9) hold meetings, conference calls, or workshops with champions from other countries who can share experiences in community access to injectables ("south to south" exchange); (10) support travel to international conferences where new information on community access to injectables is presented; (11) make presentations at professional meetings; and (12) conduct periodic program assessments to ensure program quality and effectiveness. It is especially important to involve medical professionals as champions and spokespersons and inform health specialists that key international medical professional organizations as well as the WHO have endorsed the safety and acceptability of community access to injectables.

Concerns of community members. Women of reproductive age and FP clients, their families, and community members may be concerned about safety issues, possible side effects, privacy, and confidentiality. Men may be concerned about women having control over their reproduction, the potential for infidelity, and women's clandestine use. Parents may be worried about sexual activity among youth. Some people may be opposed to use of any form of family planning or may favor specific methods. Various types of community education—community health talks, small group meetings, home visits, individual discussions, and large meetings—may be needed to address allay fears and refute rumors and misinformation. One approach to addressing concerns of community members might be to arrange for a TV or radio soap opera to discuss the major issues in its story line and show how people sought correct information and discussed their concerns with others. Chat and call-in radio and TV shows also offer the opportunity to present accurate information. On the other hand, mass media coverage can raise the risk of stirring up controversy and having people seeking the limelight inflaming the issue and spreading false information.

Concerns of community leaders and organizations. Community leaders and organizations may not think that community access to injectables is needed, and they may be concerned about safety issues, becoming embroiled in controversy, and having to take a public stand on a sensitive issue. Leaders of organizations doing community work may be opposed because they have other priorities or lack the people and resources to take on provision of injectables. The working group may need to identify local champions and agencies to meet with individual leaders and community groups to understand their concerns and provide accurate information to address their concerns.

Indifference of family planning leaders. Some FP professionals may have other priorities in regard to policy changes and therefore may not want to invest time in community provision of injectables. They may also be concerned about diverting attention away from their priority issues. Advocates of community access to injectables may need to discuss policy priorities with individual family planning leaders and a larger group. The case for community access to injectables is that it meets the needs of an underserved group.

Also, a rapid rise in contraceptive use can rejuvenate the family planning program and generate support for other reproductive health initiatives.

Preparing your advocacy plan. By writing an advocacy plan, working group members can ensure a consensus on the strategy, the priority target audiences, the messages and materials to be developed, and the specific advocacy activities. The plan will help to determine the cost and people needed to conduct the advocacy work and will winnow out lower-priority activities that do not contribute to the overall objective. The plan serves as a guide to the larger group of individuals and agencies that may be involved in the advocacy work. It can be revised as circumstances change; such revisions should reflect a group consensus.

The plan's major components should include the following:

- Statement of the overall objective and strategic approach
- Identification of priority target audiences
- Messages and materials tailored to the target audience
- Description of specific activities
- Monitoring and evaluation plan

Planning activities. Based on the overall objective and strategy, prepare a list of activities to match the target audiences. Possible activities could include the following:

- Collecting additional information on the views of key decisionmakers
- Meeting individually with stakeholders who could provide useful advice and insights
- Preparing and disseminating evidence-based advocacy materials
- Organizing an observational tour of an area that provides injectables at the community level
- Inviting a knowledgeable outsider to speak to a group or meet with individuals
- Conducting a demonstration project
- Helping to draft revised service delivery guidelines
- Estimating the additional costs or savings that the new approach would involve

The action plan should be updated every 6–12 months to reflect progress to date. See Appendix A, *Example of an Advocacy Action Plan for Community-Based Access (CBA) to Injectable Contraceptives*, for a sample advocacy plan. Also note the *Activity Monitoring Chart* in Appendix A, which shows a simple way of tracking the plan's activities.

Organizing a study tour. A key factor in the decisionmaking process in several countries has been a visit to a country offering community access to injectables. Observing a community program in action has helped decisionmakers to understand how it is organized and implemented. Study tour participants can interact with clients using injectables, community health workers, and supervisors and discuss their concerns directly. The hosts of a study tour are typically the national MOH and district implementing agencies—both from the public sector and NGOs. They seem to welcome the opportunity to show their accomplishments. Many study tours have been funded by international donors, as they often involve a large delegation of stakeholders, including MOH officials, leading medical professionals, heads of organizations providing community health services, reproductive health specialists, and local representatives of donor agencies. Because study tours are expensive, they are best scheduled after considerable discussion and consultations have taken place to ensure that key decisionmakers are well informed on the key issues and a consensus is emerging. Alternatively, a two- or three-person team could conduct a study tour and report back to the decisionmakers and influencers. Ideally, the team will prepare a formal report that documents the visit and provide recommendations for moving forward.

Conducting a demonstration project. Demonstration projects are important to the decisionmaking process because they show how community access to injectables can work in underserved areas. Decisionmakers and influencers can visit demonstration project sites multiple times and gain an appreciation of the benefits of expanding access to injectables. Data and even anecdotal reports from demonstration projects can be useful. For example, in a pilot project in Malawi, community health workers have provided nearly 145,000 DMPA injections, and there has not been a single case of infection, abscess, or other complication (Olive Mtema, personal communication, September 25, 2010). Another benefit of demonstration projects is that health program managers can tailor the services to local settings before scaling them up to larger areas. By developing training tools, service delivery protocols, and systems for supervision and supplies, demonstration projects can facilitate the process of scale-up and can identify optimal modes of service management.

Step 4. Develop Advocacy Messages and Talking Points

Consistent with the advocacy objectives and strategy, advocacy messages should be tailored to the priority target audience. From the information gathered during the interviews with key stakeholders in Step 3, working group members should collect factual information that addresses the major concerns, fears, and uncertainties expressed by representatives of the target audience or key informants.

Advocacy messages should be clear and concise and should state the recommended action to be taken. They should be expressed in the words and tone typically used by the target audience. Key components of a brief message include the following:

- A statement of the main concepts to be conveyed
- Evidence, such as data, that supports the statement
- An example illustrating the human dimension to the issue, such as an individual's story
- A statement of the specific action that the audience should take (based on POLICY Project, 1999, p. III 54–55).

The level of detail will depend on the context and format/medium chosen. For example, a one-page handout would be appropriate for a brief meeting with a high-level official, while a compilation of research findings might be needed by a large group conducting an in-depth study of the advantages and disadvantages of community provision of injectables.

Selecting formats and channels. Advocacy messages are often delivered verbally by working group members and/or various policy champions in one-on-one meetings, briefings, small group discussions, workshops, speeches and panel presentations to professional audiences or other groups, and media interviews. Typically, these verbal sessions are supported by print materials such as one-page "talking points" (one-sentence summaries of key facts), factsheets, briefing packets, photographs, and charts of key data. Other formats include PowerPoint presentations, videos showing a community-based injectables program in action and commentary from stakeholders, interviews with community health providers, photos and quotes from village women, voice recordings, e-mail messages, and radio and television interviews. These materials should be appropriate to the situation; they do not have to be elaborate or costly.

The selection of the approach is based on the usual way the individual takes in information and works through issues. Verbal approaches allow advocates to provide information responding to specific concerns of the decisionmaker, pave the way for further discussion, and identify further action such as meeting with close associates of the decisionmaker. Written materials can serve as a reference and can be shared with others.

Cultivating champions and supporters. The most effective people for delivering advocacy messages are credible, well-regarded, influential spokespersons. Working group members should identify people

who can serve as policy champions, based on their position and expertise, personal contacts, ability to convey messages effectively and persuasively, and commitment to the issue. The skills of the policy champions can be further enhanced by training them to speak convincingly and use advocacy materials effectively. The working group can leverage the clout of policy champions by asking them to identify an even more influential policy champion, such as the director of the MOH family planning/reproductive health program. The working group can provide this higher-level champion with background information and advocacy materials.

Using data effectively. To prepare effective advocacy messages and evidence-based talking points, the working group needs to take the following actions:

- Collect and summarize country data related to family planning use and services—current contraceptive prevalence rate and method mix; sources of FP methods, including injectables; access to FP services; unmet need for family planning; the maternal mortality ratio; and the ratio of health providers to the population in specific areas of the country. Seek data from government health statistics, Demographic and Health Surveys, and other sources. Use modeling tools where helpful. For example, the FamPlan Model of the Spectrum System of Policy Models can show how greater adoption of injectables could affect the contraceptive prevalence rate and unmet need. This model and instructions can be downloaded from: http://www.healthpolicyinitiative.com/index.cfm?id=software&get=Spectrum.
- Summarize global technical guidance from the WHO and other influential organizations that attest to the safety and effectiveness of community provision of injectable programs.
- Synthesize and package other country experiences to demonstrate the effectiveness and safety of community-based provision of injectables. Assemble examples of operational and program guidelines for community-based provision of injectables from countries that have already developed them.

Box 3 contains some suggestions regarding key messages for community provision of injectables, with key references for each broad theme. Whenever possible, use national and local data rather than international data.

In developing messages, working group members should ensure that the data and facts are accurate. Use authoritative sources such as the WHO and other international agencies. Ensure that country-level data come from authoritative sources such as government reports and well-known experts.

Box 3. Message Ideas for Community Access to Injectables

Safety of community provision of injectables. "Given appropriate and competency-based training, CHWs [community health workers] can screen clients effectively, provide DMPA injections safely, and counsel on side effects appropriately, demonstrating competence equivalent to facility-based providers of progestin-only contraceptives." (WHO, USAID, & FHI, 2009, p. 2)

Safety of injectables. "Injectables are among the most effective contraceptive methods, after intrauterine devices, implants, and sterilization . . . WHO has identified only a few medical conditions that limit or prohibit its [DMPA] use." (WHO, USAID, and FHI. 2009)

"DMPA has been one of the most extensively researched drugs with an accumulated clinical research experience of more than 3 million months and over 1000 published scientific papers and reviews since the 1960's." (Kuku, 2006)

Women's preferences. Injectables are the fourth most popular contraceptive method worldwide, after female sterilization, the intrauterine device, and oral contraceptives. Injectables are especially popular in sub-Saharan Africa, where two in five (38%) women using modern contraceptives are using injectables. Injectable use is growing rapidly, after doubling between 1995 and 2005 (Lande & Richey, 2006).

Among women who wish to space births at least two years or wish to end childbearing altogether, between 25–50 percent of those who wish to use contraception in the future say they want to use injectables, based on national surveys in 32 developing countries (WHO, USAID, & FHI, 2009).

Benefits to underserved groups. In most countries, unmet need for family planning is higher among rural women compared with those living in urban areas. In sub-Saharan Africa, unmet need for FP is greater in rural areas in 22 of 31 countries for which national survey data are available. Turning to wealth indicators, in nearly all countries unmet need for family planning is much higher among women in the lowest wealth quintile, compared with those in the highest wealth quintile. Providing FP services in the community would help to redress this imbalance (Westoff, 2006).

Benefits to the family planning program. Provision of injectables in the community does not replace existing injectable use. A large proportion of women initiating injectable use in community programs are new users. Thus, community programs increase overall contraceptive prevalence and reduce unmet need for family planning.

Where injectables have been introduced through community sources, uptake can be rapid, thus reducing unmet need for FP. For example, use of injectables in the "Last 10 Kilometers" project areas in Ethiopia more than doubled in just four years, increasing from 11 percent of married women of reproductive age in 2005 to 27 percent in 2009. Nearly two-thirds (64%) of injectable users obtained their method from a health post (John Snow Inc. Research and Training Institute, 2009).

For more references, consult the toolkit compiled by the Knowledge for Health Project at: http://www.k4health.org/toolkits/communitybasedfp/cba_injectables .

Use of injectables has increased rapidly in many sub-Saharan African countries, especially over the past decade. Among countries where injectable use makes up at least 10 percent of total contraceptive use, the use of injectables has risen sharply (see Appendix B, Figure 1). Furthermore, the proportion of contraceptive prevalence attributed to injectables has also soared, indicating that injectables constitute a major proportion of new contraceptive users (see Appendix B, Figure 2, Ross, 2010).

Benefits to women's health. If women were able to meet their fertility desires by preventing unintended pregnancy, their risk of maternal morbidity and mortality would be reduced by 25 percent (Collumbien et al., 2004).

Reproductive rights. International treaties, agreements, and conference declarations regarding human rights have affirmed the right of individuals to decide the number, timing, and spacing of their children and the right to the highest attainable standard of health (UNFPA, 2010).

Step 5. Plan to Monitor and Evaluate Progress

Design your monitoring and evaluation (M&E) plan to meet the information needs of specific people, such as program managers, advocates, and donors. The purpose of the M&E plan is to ensure that the advocacy initiative is being implemented according to plan and is having some effect. For advocacy work, it is desirable to take stock regularly, at least through informal processes, to determine whether the strategy or materials need to be changed. As activities unfold, it is useful to note what approaches worked well and which ones could have been done differently. In advocacy work, the process of periodic reviews and adjustments based on the reactions and feedback of key individuals and audiences is a form of monitoring.

Evaluation is also needed to gauge progress and shift to new strategies as necessary. It can take the form of a discussion among the most active working group members to reflect on their work or can be based on a checklist of desirable changes in the policy environment and attitudes of decisionmakers.

For large advocacy initiatives, the working group may wish to establish a few indicators that are consistent with the overall objective. Following are some explanations regarding possible indicators for advocacy work.

Setting outcome indicators. Outcome indicators should reflect a change in the target audience or beneficiaries, such as a change in attitudes, knowledge, and/or behavior. These changes should be plausibly linked to the advocacy activities undertaken. Select only a few outcome indicators that can be readily measured (within your existing budget and resources) and that represent major signs of progress toward your overall objective. Possible outcome indicators could be as follows:

- At least five senior MOH officials make public statements supporting community provision of injectables.
- A representative group of stakeholders drafts revised service delivery guidelines with input from MOH officials responsible for reproductive health and community services.
- The national professional associations of doctors and nurses formally approve the draft service delivery guidelines.
- Health officials in a specific district develop an implementation plan and budget to implement community provision of injectables and ask the national MOH to permit them to do a demonstration project.

Establishing some short-term outcome indicators that are more readily attained than the overall objective will help working group members to focus on feasible tasks rather than becoming frustrated because progress toward the overall objective is slow.

Setting output indicators. Output indicators should reflect the activities, actions, and products needed to achieve the outcome(s). They differ from the list of activities because they include an accomplishment or interaction with the target audience that will lead to the outcome indicator(s). Examples of output indicators include the following:

- At least 10 MOH officials meet with a champion or representative of the working group.
- The working group prepares and pretests a presentation and handouts that address concerns of physicians and other medical personnel.
- A policy champion assisted by the working group holds discussions with at least five leaders of medical societies.

- The working group expands to include representatives from at least 10 stakeholder agencies.
- At least 20 stakeholders participate in a meeting in which the issues surrounding community provision of injectables are discussed.

The working group should avoid creating too many indicators and activities. Thinking of a 6–12 month timeframe, what activities can be implemented and what outcomes can be expected?

Some donors and supporters may wish to know whether the capacity of the advocacy group has improved. The following are examples of factors related to an organization's capacity:

- The quality, quantity, and reach of various communication activities (see Sullivan et al., 2007)
- Progress in building relationships with decisionmakers and key stakeholders
- Improved skills, management systems, and/or financial stability

If it is important to collect information on any of these factors, the working group should develop one or more outcome indicators to capture the key concept. Julia Coffman (2009) provides some examples of indicators and a worksheet for use in planning and prioritizing advocacy evaluation.

Reporting. As the advocacy work is implemented, the working group members and key stakeholders should receive periodic updates on the activities and signs of progress toward the outcome indicators. These updates will help to keep them engaged and active and also encourage them to report information on their activities.

Step 6. Implement the Advocacy Plan

With the benefit of careful planning and consultation, the working group can forge ahead to implement the action plan. For each activity, the working group needs to identify the person or organization responsible, agree on a timeframe, and ensure that the necessary support (personnel, materials, funds) is available. Encourage flexibility, as it will help the working group to be better prepared to resolve urgent matters, delays, or other unanticipated circumstances.

Even with the best plans, the policy environment can change without warning. New leaders may be elected or appointed, key government officials may leave their jobs, controversies may erupt, and priorities can change. In these situations, advocates need to adapt to the new environment. In other cases, changes in the advocacy plan may be needed as the work advances and advocates learn more about the positions of key decisionmakers. In addition, revising messages and building relationships with other influential people may be needed.

Assuming that the demonstration project is successful, advocates will need to press for expanding the initiative to more areas or a national scale. This phase can be challenging because new opponents can emerge to block expansion and some regions may lack sufficient health providers and facilities to provide the necessary supervision. Scale-up involves many small and large adjustments throughout the health system. Advocates of community access to injectables can be helpful in identifying areas that need attention and ensuring that health officials and providers as well as community members have accurate information and understand the benefits of community access to injectables.

Another factor that may emerge within the next two years is the availability of injectables that can be injected under the skin rather than into a muscle, as discussed in Box 4, *Wave of the Future—Subcutaneous DMPA*. This different injectable formulation may facilitate community provision of injectables and remove some of the concerns about injections provided by non-medical personnel. Field studies will help to inform service delivery guidelines and gauge women's views on the new formulation.

CONCLUSIONS

Advocacy is a continuous process of disseminating accurate information, refuting misinformation, creating a dialogue, and slowly building support among key decisionmakers as well as the larger community of stakeholders. Typically, advocacy involves a series of incremental steps that are periodically readjusted to respond to changes in the overall policy environment. This careful process is needed because the policy change could be blocked by a few individuals or derailed by vociferous opposition from respected leaders, such as doctors and religious leaders. The working group plays a key role in advocacy and in all stages of policy change and implementation. Policy champions, such as medical providers and respected public figures, are often highly effective in reaching and informing key decisionmakers. Often the most persuasive action that advocates can undertake is to take skeptical decisionmakers on a tour of communities that provide injectables, either through a demonstration project in-country or in another country.

Provision of injectables by community health workers is a controversial topic among some groups, especially those for whom it is a new idea. Working toward a consensus among the decisionmakers can take years of careful work. Advocates must be patient and remain focused on changing the climate of opinion. They should be ready to take advantage of openings in the "policy window," such as a change of personnel, enthusiasm generated by a dynamic speaker, and demands for making reproductive health services available in underserved areas.

Box 4. Wave of the Future—Subcutaneous DMPA

A new type of injectable is awaiting approval in many countries, following approval in the United States and the United Kingdom. Known as depo-subQ provera 104, or depo sub-Q, this new formulation provides a lower-dose of DMPA and is injected under the skin rather into the muscle. Because it will be available only in prefilled, single-use syringes, health specialists believe that it could be easier for lower-level health workers to provide in the community or in clients' homes. Field studies are currently underway in Kenya, Malawi, Rwanda, Senegal, and Pakistan to plan the introduction of this new injectable. It is expected to be available in 2011 (PATH, 2010).

APPENDIX A. EXAMPLE OF AN ADVOCACY ACTION PLAN FOR COMMUNITY-BASED ACCESS (CBA) TO INJECTABLE CONTRACEPTIVES

Provided by Family Health International

Background on injectable contraceptives

Injectable contraception such as Depo-Provera (DMPA) is an extremely popular family planning method due to its safety, effectiveness, ease of use, privacy, and convenience. In several countries in sub-Saharan Africa, use of injectable contraceptives has increased dramatically in recent years and now dominates the method mix.

Provision of injectable contraceptives by trained paraprofessionals such as community-based distribution (CBD) agents was demonstrated to be safe and effective in Bangladesh and Latin America as early as the 1970s and 1980s.

Research has further demonstrated that with proper training, this cadre of worker can provide DMPA as safely as can nurses and can achieve high rates of acceptability and satisfaction among their clients. Studies conducted by Family Health International (FHI) with local partners in Uganda during 2004–2005 and in Madagascar during 2006–2008 confirmed this conclusion.

A note about terminology: The conventional term "community-based distribution" is often used to describe the work of non-medical volunteer health workers who provide family planning or other commodities in their community. However, in this document, the authors sometimes refer to *access* rather than to distribution, such as in the phrase "community-based access (CBA) to injectable contraceptives." The term is inclusive of other types of community outlets for family planning such as drug shops and depots. Additionally, *access* embraces the full range of services provided by CBD agents and agents at these other outlets, which are not limited to distribution but also include counseling, education, and referrals.

Policy issues and advocacy challenges

To influence change in policy and practice, many advocacy efforts have been made over the past years, including champion activities, stakeholder meetings, dissemination events, co-branded advocacy kits, presentations, and advocacy targeted specifically toward professional associations.

While some incremental progress has been shown—such as revision of CBD service delivery guidelines to include injectable provision and the growing numbers of groups and agencies supportive of the innovation—to date, there is still no national policy or guideline that states that community-based workers may provide injectables. Feedback from the Ministry of Health (MOH) has indicated a perceived need for additional research evidence before policy changes can be considered.

Furthermore, despite the method's popularity, many women—the majority of whom reside in rural areas with few health facilities—have relatively little access to injectable contraception because its provision is generally limited to clinics.

There is a pressing need for focused and dedicated advocacy with the MOH, program managers, professional medical associations, service providers, and other stakeholders to garner their support for CBA to injectables.

Potential barriers

To arrive at an amenable policy environment, a successful CBA to injectable contraceptive program calls for stakeholders who are informed, have positive attitudes toward community-based provision of injectables, and actively support the programs. Identifying, understanding, and addressing the specific concerns of various stakeholders will be the key to reducing potential barriers to CBA to injectables.

Possible barriers could include the following: safety (i.e., injury and infection prevention through proper injection technique and disposal of needles); adequate supervision for CBD agents; job security for clinic-based providers; and program sustainability. Anecdotal evidence also indicates that cultural and religious beliefs, such as the high value placed on large family or clan size, may play an important role in community attitudes toward family planning programs. Gender roles, myths, and misconceptions are also commonly cited as possible barriers to CBA to injectables.

All of these potential barriers will need to be carefully addressed through sensitization and advocacy efforts and through strong collaboration with various stakeholder groups.

Goals and strategic approach

Only through positive changes in stakeholder attitudes can a more enabling policy environment be created. It is then that national regulations and service guidelines can be addressed and amended and a scale-up strategy developed and implemented to further replicate the successful CBA programs for injectables.

Through tailored and targeted evidence-based advocacy measures, medical professionals, policymakers, and other key opinion leaders will be informed and convinced that provision of injectables by community-based workers is safe and effective and that changes to policy and practices have many advantages, including but not limited to the following:

- **Improved contraceptive prevalence rates.** The non-clinical provision of injectable contraceptives can address the issue of limited access to services, particularly in rural areas. The powerful reach of community-based family planning programs was revealed in a recent assessment. About 57 percent of the women who participated in a pilot study had never accessed family planning services before. Increased access to services through community-based provision of injectables therefore has immense potential to increase contraceptive prevalence in rural communities.

- **Reduced workload for medical providers.** In the pilot study, 43 percent of women had shifted to community-based services from clinical services—a move that liberated medical personnel so they could focus on tasks that require greater skill. Community-based provision of injectables shifts this task to a less-skilled cadre of workers, reducing the workload for clinic-based providers who are already in short supply.

- **Increased cost-effectiveness.** Community-based provision of injectables can also be a cost-effective strategy for meeting the unmet family planning needs of the rural poor. Substantially fewer resources are needed for the community-based provision of injectables

than are needed to build and staff additional clinics. Such clinics are impractical in remote, sparsely populated areas. Allowing community-based workers to provide the locally preferred FP method is also likely to increase the cost-effectiveness of the existing CBD programs.

The goals of this advocacy strategy are the following:

1. To increase awareness of and support for CBA of injectables among stakeholders and key leaders at national and district levels

2. To amend national reproductive health policies and service guidelines to accommodate provision of injectables by trained paraprofessionals such as community-based workers and other cadres

3. To develop a national scale-up strategy for the introduction of community-based access to injectables in additional districts and programs

4. To establish an advocacy resource team—consisting of people and organizations that hold a stake in CBA programs for injectables—to guide and support the innovation

Target stakeholder audiences

Policymakers and MOH FP program managers: These are the primary target audiences and include MOH officers such as the directors of family planning and RH divisions, assistant commissioner, regional reproductive health coordinators, the director general, members of Parliament (MPs) and district directors of health services.

Professional medical associations: Healthcare providers can have a strong influence over policy changes and scale-up of CBD of injectables. Some doctors and nurses have concerns about various aspects of the practice (e.g., safety, job security, etc.) and may yet to be convinced by the evidence. Significant outreach to this audience will be required.

Service providers: To gain their support, concerns among health professionals will need to be heard and addressed.

Donors: An essential component of institutionalization and scale-up includes dedicated resources, either through MOH budgets or incorporation into Requests for Proposals from other development agencies.

Future potential implementing partners: Partnering with NGOs who have strong existing community-based distribution programs is an important success factor in scale-up of CBA of injectables.

Media/general public: Myths and misconceptions regarding family planning, and this intervention in particular, must receive the necessary attention to ensure that accurate information about CBA of injectables is disseminated via media outlets. This will preempt negative or inaccurate press and may also create demand, thus influencing policymakers.

Champions

An advocate or "champion" of family planning is an opinion leader or figure of authority who uses his or her expertise and professional contacts to help bridge the gap between research results and changes in family planning policy and practice.

District-level champions can raise awareness and inform the community through various advocacy activities such as holding public forums and airing radio shows. National-level champions also facilitate change by applying their knowledge and positions of influence to help create a more supportive policy environment.

Planned activities

Advocacy activities in this strategy focus around three main areas:

1. Communication with and education of stakeholders (see specific activities listed below).

2. Provision of technical assistance to the MOH to amend national guidelines and policies. Once amended, development of a national strategy for putting the guidelines and policies into action.

3. Provision of technical assistance and facilitation of policy and program dialogue among stakeholders to develop a national scale-up strategy.

For timeline and status of all advocacy strategy activities, refer to the Activity Monitoring Chart in Appendix 11.

Description of communication and education activities

Sensitization meetings. To educate, seek support, and facilitate a positive environment for changes in policy and practice, the advocacy resource team would do the following:

- Present and discuss FP and CBD of injectables with the parliamentary forum, in conjunction with the Population Secretariat.

- Present and discuss FP and CBD of injectables with the women parliamentarians' association.

- Arrange one-on-one meetings about CBD of injectables with key members of the national drug authority, nursing and midwifery councils, association of obstetricians and gynecologists, clinical officers association, and private practitioners. Goals of meetings include obtaining buy-in and support around issues of access to services and disseminating advocacy materials.

- Hold a national-level advocacy seminar with stakeholder institutions, to include media participation.

- Convene meetings for health workers at district-level clinics to discuss family planning and CBA of injectables, including visits to CBD homes.

- Arrange advocacy presentation on costs and benefits of CBA of injectables for donors and international NGOs.

- Present to and discuss CBA of injectables with the health policy advisory committee.

Learning exchanges. To promote South-to-South sharing of experiences and knowledge transfer, the advocacy resource team will do the following:

- Arrange study tours of MPs to in-country sites providing CBA of injectables
- Arrange a study tour of MPs, MOH leaders, senior MOH managers, FP/RH specialists, and other development partners to a neighboring country

Champion activities. To leverage support for CBA of injectables from local opinion leaders and authority figures, the advocacy resource team will do the following:

- Identify district- and national- level family planning champions who can work toward changing community attitudes and practices (district) and national-level policies and practices (national).
- Arrange district workshops to sensitize district leaders and mobilize champions. These will include presentations to district and sub-county councils.
- Conduct advocacy workshops at the sub-county level to introduce champions to community stakeholders and increase awareness about CBA of injectables.
- Conduct a two-day orientation workshop on FP and CBA of injectables for national-level champions.
- Provide technical assistance for national-level champions to make presentations on CBA of injectables to the FP/RH Working Group and to senior management at the MOH.
- Provide technical assistance for a champion (or other person of influence) to present at the national health assembly meetings.
- Provide financial support and technical assistance to district champions to carry out their workplans.

Technical assistance to media. To ensure evidence-based news and other communications about CBA of injectables, the resource team will do the following:

- Provide technical assistance to media in writing articles about CBA of injectables.
- Provide technical assistance to the MOH and other stakeholders in development of medically accurate, evidence-based press releases.

Advocacy materials

Supportive materials used for advocacy activities include CBA of injectables advocacy kits, implementation handbooks, job aids, fact sheets, and policy and technical briefs developed by FHI and partners. Existing research evidence will be repackaged as necessary to present information to stakeholders in ways that facilitate and increase the likelihood of their use in decisionmaking.

Partners

Advocacy activities will be implemented by local NGOs and other implementing partners, as well as family planning stakeholders and champions.

Monitoring and evaluation

The Logical Framework in Appendix I presents the rationale for the advocacy activities and their expected outputs, objectives, outcomes, and impacts.

To track status of advocacy activities, an activity monitoring chart is provided in Appendix II, which is to be updated regularly by staff of this project.

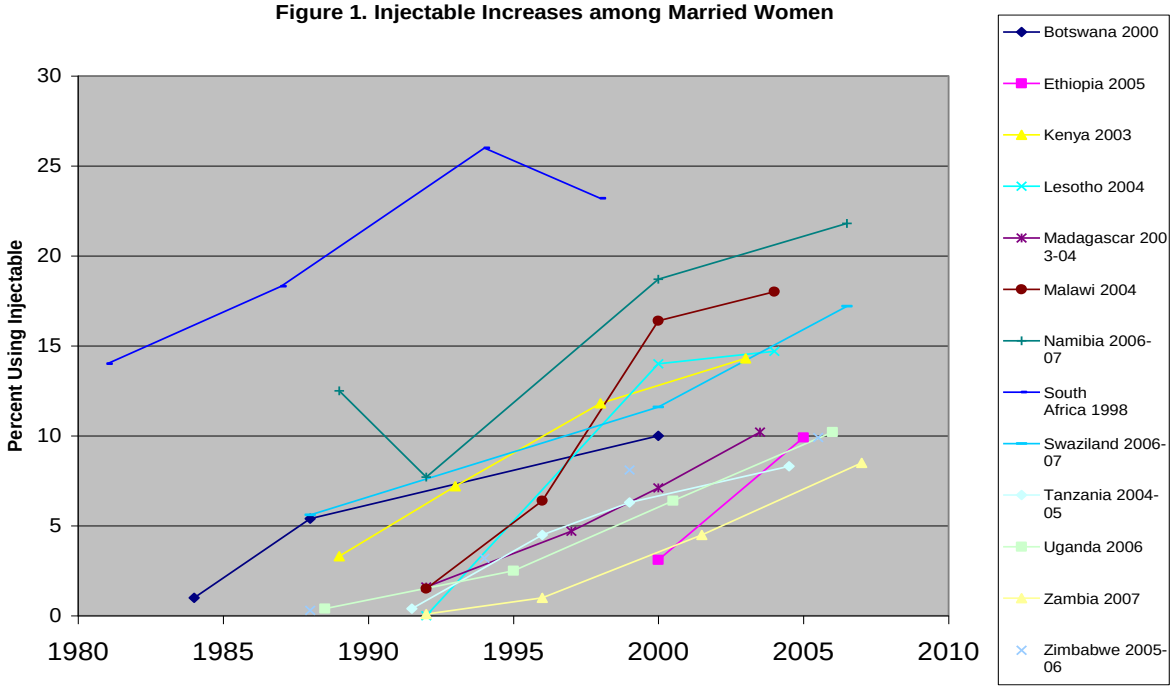
Activity Monitoring Chart

X - Scheduled, x - Done	January - June																							
Activity	Jan				Feb				Mar				April				May				June			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Sensitization meetings																								
Organize and lead meeting of the working group to conduct advocacy on CBD of DMPA																								
Hold national-level advocacy seminar with stakeholder institutions on costs and benefits of CBD of injectables, to include media participation																								
Meet with women ministers and parliamentarians																								
Conduct district CBD of DMPA review meetings																								
Conduct meeting with parliamentary forum																								
Convene meetings on FP and CBD of DMPA for health workers at district level																								
Meet with advocacy partners to provide them with advocacy presentation on costs and benefits of CBD of DMPA																								
Present to and discuss CBD of DMPA with health policy advisory committee																								
Hold one-on-one meetings and 1 day seminars on CBD of DMPA with key members of national drug authority, nursing and midwifery councils, association of obstetricians and gynecologists, and private practitioners																								
Learning exchanges																								
Conduct study visits of parliamentarians to pilot CBD of DMPA sites																								
Conduct study tour of MPs, MOH, development partners to neighboring country																								

APPENDIX B. CHANGES IN INJECTABLE USE IN 13 AFRICAN COUNTRIES

Selecting the countries in sub-Saharan Africa in which injectables account for at least 10 percent of contraceptive use, data from national surveys since 1980 were analyzed to determine trends in use of injectables. Figure 1 shows that injectable use has risen rapidly in all 13 countries. These data show that once injectable use is established in African countries, it escalates quickly.

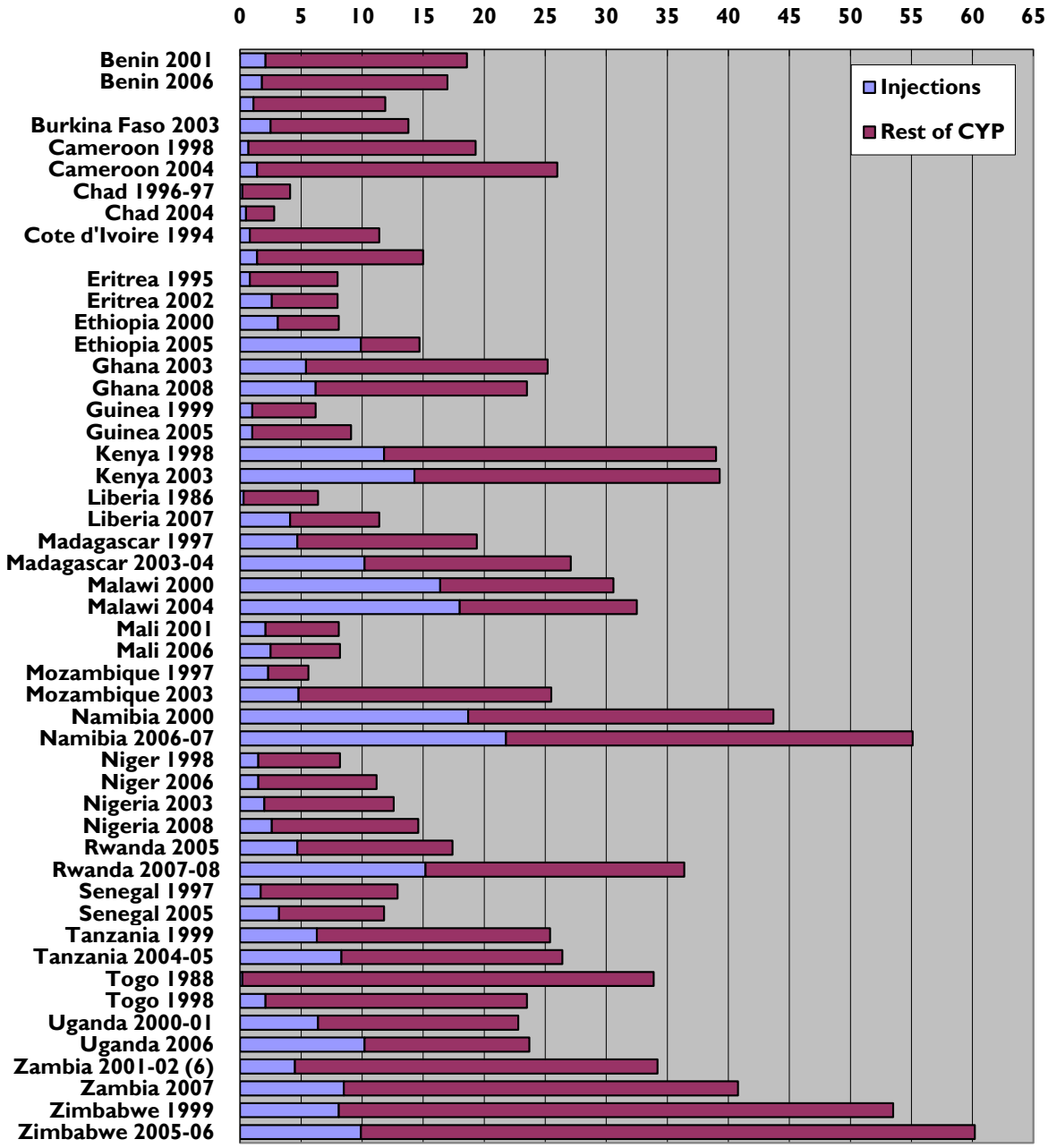
Figure 1. Injectable Increases among Married Women



Source: Analysis by John Ross, Futures Group, using national survey data from 13 sub-Saharan African countries

Furthermore, injectables account for a large proportion of the growth in contraceptive prevalence in the sub-Saharan Africa, and the dominance of injectables over other contraceptive methods continues to grow (see Figure 2). The highest proportion of injectable use is in Malawi and Ethiopia, where injectables account for 68 percent and 55 percent of contraceptive prevalence, respectively. Most countries show a range of 30–40 percent injectable use as a proportion of overall contraceptive prevalence. While dominance of a single method in the contraceptive mix is not necessarily desirable, these data show that there is strong demand for injectables in Africa.

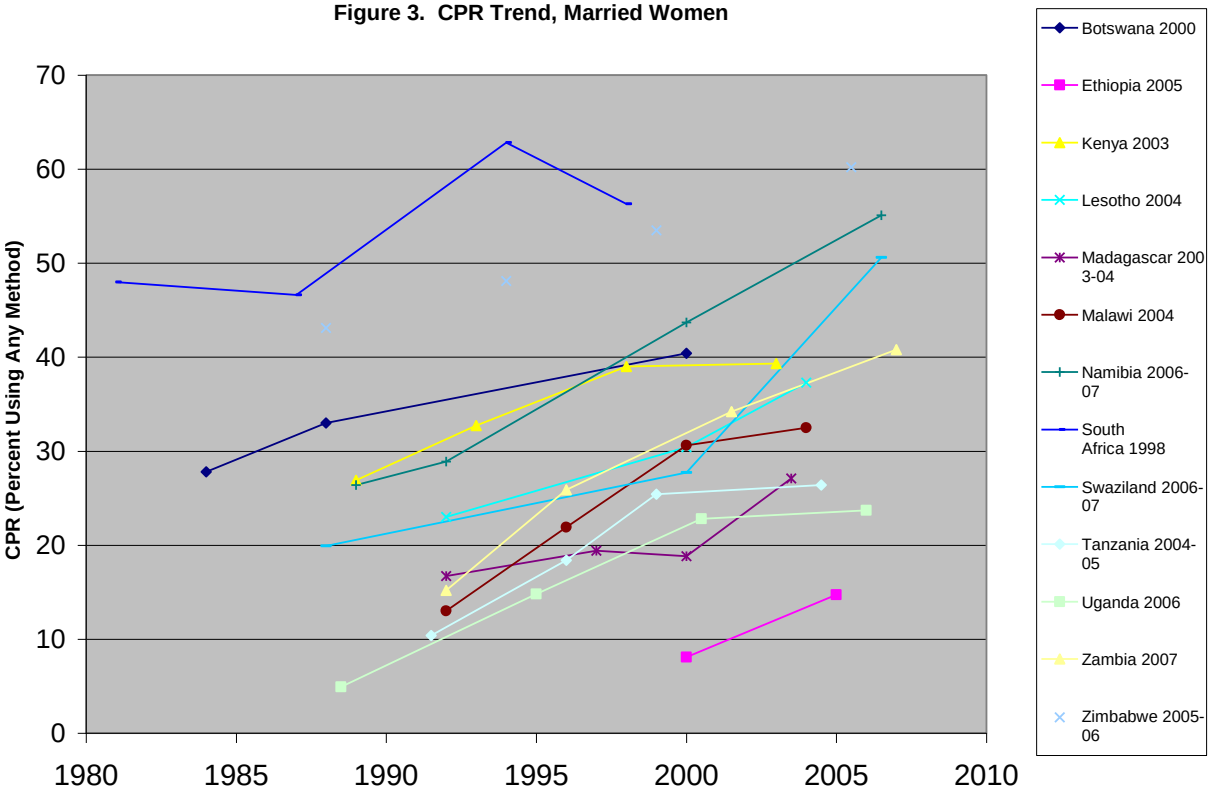
Figure 2. CPR with Portion Due to Injectables, Married Women, Two Latest Surveys per Country



Source: John Ross, Futures Group. 2010. Unpublished analysis of national survey data.

The growth in injectable use has occurred in the context of rising contraceptive prevalence rates, which indicates that injectables are not replacing other methods but are indeed driving the trend toward higher contraceptive prevalence (see Figure 3).

Figure 3. CPR Trend, Married Women



Source: Analysis by John Ross, Futures Group, using national survey data from 13 sub-Saharan African countries

APPENDIX C. DRAFT POLICY ADDENDUM: ADDENDUM TO FAMILY PLANNING SERVICE STANDARDS

Provided by Family Health International

Preface

Providing high-quality reproductive health services requires sound, evidence-based knowledge and clinical practices. Consequently, there is a need to review and update guidelines and manuals to ensure that service providers are informed about new evidence and practices.

Since the publication of the National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights, new evidence and a growing international consensus supports the provision of injectable contraceptives (e.g., Depot-Medroxyprogesterone Acetate (DMPA) and Noristerat) by community health workers (CHWs).

New research evidence
The pilot study, conducted in a rural district, confirmed findings from other parts of the world—that CHWs can safely and feasibly provide Depo Provera in the community. Moreover, this practice was acceptable in the communities. The project was scaled up in two districts by nongovernmental organizations.

Growing international consensus
New international guidance has emerged, including the World Health Organization's (WHO) *Family Planning: A Global Handbook for Providers (2007),* which states that "anyone trained to give injections and to handle needles and syringes properly, including appropriate waste disposal" can provide injectable contraceptives. Additionally, the WHO/USAID/FHI Technical Consultation on Expanding Access to Injectable Contraceptives (Geneva, June 2009), which brought together 30 technical and programmatic experts, concluded that there is sufficient evidence to support the introduction, continuation, and scale-up of community-based provision of progestin-only injectable contraception by trained community workers.

Provision of injectables by community health workers

According to the Demographic and Health Survey, injectable contraceptives are women's preferred contraceptive method, and many women want to space or limit births but are not using contraceptives. Therefore, integrating injectable contraceptives into the existing services offered by community health workers has the potential to increase access to family planning and reduce the total fertility rate. CHWs are the primary healthcare providers in the community; they reside and work within the community and are well known to the community members.

Provision of injectables by CHWs has the potential to improve quality of care, improve method mix and choice at the community level, as well as greatly reduce barriers for those seeking contraceptives in remote, rural areas. It can also help to reduce the burden on overworked health professionals and the short-staffed health system.

This addendum

In response to the new evidence and growing consensus on the safety, feasibility, and efficacy of the provision of injectable contraception by trained CHWs, as mentioned above, the Ministry of Health recently developed this addendum to the service delivery guidelines and service standards. Providers,

managers, program implementers, and supervisors should review this addendum carefully to be fully informed, and they are requested to refer to this addendum when counseling and referring clients.

1. GOAL AND OBJECTIVES

Goal: To improve the uptake and continuation of injectable contraceptives in areas with limited access to facility-based family planning services by allowing their provision by CHWs, thereby promoting method mix and choice at the community level.

The objectives are to

- Promote method mix and choice at the community level;
- Increase the number of family planning service providers in the community;
- Increase access to injectable contraceptives in the community;
- Equip CHWs with knowledge and skills to safely provide injectable contraceptives to women of reproductive age; and
- Monitor uptake of injectable contraceptives and resource utilization.

2. CORE AREAS, GUIDING PRINCIPLES, AND GUIDELINES

To achieve the above objectives, this section of the addendum outlines the core areas, guiding principles, and guidelines for managers in the public and private sectors who will work with and support CHWs to provide injectable contraceptives at community level. It is not adequate to only increase access by communities but to ensure safety and quality; hence, the importance of these guidelines.

A. Training

Comprehensive, competency-based training is a critical requirement in ensuring the quality delivery of injectable contraceptive services at the community level.

Guiding principle: Build the capacity of CHWs with the required knowledge, skills, and attitudes to advocate for and provide high-quality injectable contraceptive services at the community level.

Guidelines

- Equip CHWs with skills to counsel on informed choice (i.e., the full range of available family planning methods, in addition to injectable contraceptives).
- Train CHWs in safe injection techniques, infection prevention, and safe disposal of waste.
- Also train CHWs in basic reproductive physiology, FP methods and their mechanisms of action, supportive counseling techniques, management of side effects, re-injection, indications for referrals, medical eligibility, and appropriate use of screening checklists.
- Mandate that only family planning trainers approved by the MOH train CHWs in the provision of injectable contraceptives.
- Have district health officers and nurse supervisors be responsible for organizing and training CHWs at the district level.
- Organize and manage refresher trainings for CHWs every year and make updates whenever necessary.

B. Service Delivery

Injectable contraceptive services should be client-friendly, free of charge in accordance with the MOH policy, safe, easily accepted, and utilized by the community.

Guiding principle: Promote, advocate use of, and ensure availability of injectable contraceptives in the community.

Guidelines

- Have the officer in charge of the health facility be responsible for ensuring availability of injectable contraceptives and related supplies at the community level.
- Identify, empower, and utilize existing community groups to create demand for injectable contraceptives (e.g., women and youth groups, male gatherings, and religious groups).
- Provide injectable contraceptive services free of charge in accordance with the MOH policy.
- Emphasize the importance of confidentiality in all provider-client interactions, documentation, and recordkeeping
- Ensure the safe provision of injectable contraceptives by training and continuing to supervise CHWs on safe injection techniques, infection prevention, and safe disposal of waste.
- Ensure use of the checklists in screening for medical eligibility and referral to facility-based medical health providers as necessary.
- Advise and agree on the places where family planning services should be provided (e.g., local clinics, health outposts, the homes of CHWs, and/or door-to-door at clients' homes).
- Develop strategic and sustainable partnerships with community, religious, and other influential leaders.

C. Monitoring and Supervision

Effective monitoring and supervision are important components in the provision of sustainable, high-quality injectable contraceptive service provision at the community level.

Guiding principle: Strengthen monitoring and supervision of injectable contraceptive service delivery within the existing systems.

Guidelines

- Reinforce the use of national monitoring and supervisory tools by all supervisors at the district and community levels.
- Reinforce monitoring of uptake of injectable contraceptives using the national health management of information system forms.
- Ensure correct, consistent, and complete documentation, recordkeeping, and reporting of injectable contraceptives data in the national register and tally sheets.
- Conduct monthly supportive supervision of CHWs providing injectable contraceptives using a competency assessment checklist.
- Ensure that supervisors provide regular supportive feedback to the CHWs on their performance; supervisors should also report on CHW performance monthly at the community level and quarterly at the district level.
- Develop and implement on-the-job training activities during supervisory visits.

- Have the District Health Officer facilitate an assessment of community-based injectable contraceptive services every six months to evaluate progress.

D. Quality Assurance

Quality assurance is a system for establishing and monitoring the implementation of standards and practices in injectable contraceptive service delivery. It should ensure safety of the client, service providers, and the community.

Guiding principle 1: Integrate injectable contraceptive services into national quality management plans to ensure high-quality service delivery.

Guidelines

- Ensure that quality improvement activities include injectable contraceptive service delivery at the community level, with a focus on competence of the provider, management of resources, documentation, and recordkeeping.
- Ensure timely ordering, proper handling, and storage of injectable contraceptives and supplies.
- Support CHWs to uphold infection prevention standards, safe injection techniques, and safe disposal of syringes.
- Ensure continuous supply of personal protective equipment and other infection prevention supplies for CHWs providing injectable contraceptive services in the community.
- Uphold national standard guidelines on waste disposal in relation to injectable contraceptive service provision.
- Continuously orient CHWs to post-exposure prophylaxis (PEP) services in each district.
- Support CHWs to easily access PEP services when needed.

Guiding principle 2: Ensure the high competence and performance of CHWs in delivering high-quality injectable contraceptive services, thereby promoting professionalism and attracting and retaining clientele. CHWs should ensure clients' safety at all times.

Guidelines

The quality of care for family planning services is based on the following six essential elements: (1) method choice; (2) sharing of information; (3) providers' technical competence; (4) interpersonal relations between providers and clients; (5) follow up and continuity mechanisms; and (5) constellation of services. The guidelines are as follows:

- Uphold informed choice on injectable contraceptives.
- Provide comprehensive information on all contraceptive methods available to enable clients to make informed choices.
- Reinforce use of client screening check list before initiating clients on injectable contraceptives.
- Reinforce interpersonal relations between CHWs and clients to enhance respect, privacy, and consideration of shortening the waiting time, promoting compliance and access; hence increasing demand.
- Institute a continuous system for counseling, follow up of clients, compliance, and support as needed.

E. Logistics Management

A sound logistics system ensures the smooth distribution of contraceptive commodities and other supplies so that each service delivery point has sufficient stock to meet clients' needs. This includes injectable contraceptives and supplies that will be administered and used at the community level.

Guiding principle: Institute a well-run logistics system, which will ensure that all supplies are in good condition and timely and costs are controlled by eliminating overstocks, spoilage, pilferage, and other kinds of waste.

Guidelines

- Co-ordinate an effective and efficient logistics management system down to the community level with correct, complete, and consistent documentation.
- Ensure that CHWs collect injectable contraceptives and required supplies from the health center.
- Enforce proper recordkeeping and maintenance of national registers and tally sheets to prevent overstocking that might lead to wastage and stockouts.
- Maintain an effective acquisition, transportation, and storage system of injectable contraceptives and supplies at the community level.
- Ensure timely delivery of all contraceptive commodities and other supplies when and where they are needed and in good condition.
- Ensure that CHWs have and use safe waste disposal containers at all times and have a safe means of transporting these to health facilities for disposal.
- Reinforce national standards for disposing expired injectable contraceptives and medical waste.
- Ensure that CHWs providing injectable contraceptive services are equipped with the minimum supplies and materials for them to carry out their job (e.g., lockable contraceptive storage box, waterproof carrier bags, calendars, registers, and tally sheets, contraceptives and safe waste disposal container for used syringes).

3. SERVICE DELIVERY OUTLETS

In line with the health policy of the MOH, services will continue to be provided through government, non-governmental, and private sector facilities, units, and outlets. The following are recognized outlets of FP service provision:

- Facility-based outlets such as hospitals, health centers, and dispensaries
- Outreach services, including mobile clinics
- Community-based outlets (e.g., by CHWs, drug shops, and dispensing machines)
- Social marketing
- Private sector facility such as clinics, maternity wards, nursing homes, pharmacies, and drug retail shops

Family Planning Service Provision by Cadre of Staff							
Type of Service	**Social marketing agent**	**Village Health Team**	**Nursing Assistant**	**Nurse**	**Midwife**	**Clinical Officer**	**Doctor**
Counseling		☐	☐	☐	☐	☐	☐
Home visits		☐	☐	☐	☐	☐	☐
Health education talks		☐	☐	☐	☐	☐	☐
Combined oral contraceptives		☐	☐	☐	☐	☐	☐
Progesterone only pill		☐	☐	☐	☐	☐	☐
Condoms		☐	☐	☐	☐	☐	☐
Depo-Provera inj.		☐		☐	☐	☐	☐
Noristerat inj.		☐		☐	☐	☐	☐
Intrauterine device				☐	☐	☐	☐
Bilateral tubal ligation					☐	☐	☐
Vasectomy					☐	☐	☐
Implant insertion				☐	☐	☐	☐
Emergency contraception		☐	☐	☐	☐	☐	☐
Periodic abstinence methods		☐	☐	☐	☐	☐	☐
LAM		☐	☐	☐	☐	☐	☐
Supervision of lower cadres				☐	☐	☐	☐

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