



Improving Access to Contraception in Akwa Ibom State, Nigeria: Task-Sharing Provision of Injectable Contraceptives and Implants with Community Health Extension Workers



Community Health Extension Workers (CHEWs)

CHEWs significantly outnumber nurses and midwives in Nigeria: 36,737 CHEWs vs. 5,604 nurses and midwives.¹ CHEWs are classified as ‘upper-lower’ health staff, trained to offer different health services at the facility and community levels. They are expected to spend half of their time on community-based functions and the other half in the clinic. However, because of the chronic shortage of higher cadre health staff in some parts of Nigeria, CHEWs are being deployed to work in static health facilities. By not being able to provide implants due to policy restrictions or lack of capacities, clients at static health facilities managed by CHEWs might have limited access to this highly effective long-acting reversible contraceptive.

implants and injectable contraceptives (DMPA) in facilities, and increase demand for both contraceptive methods through community-based outreaches. E2A documented the interventions in Akwa Ibom through the collection and analysis of quantitative data from the Health Management Information System (HMIS), and qualitative data from key informant interviews and focus group discussions with CHEWs and facility heads where the interventions took place. This technical brief is a product of that documentation process and demonstrates the impact of those added capacities on contraceptive availability and uptake in the two LGAs of Akwa Ibom. The evidence in this brief accompanies an operations research study conducted by E2A in Cross River and Kaduna states. This study showed implant provision could be task-shifted to this cadre while achieving the same levels of client satisfaction and volumes of

About E2A

The Evidence to Action for Strengthened Family Planning and Reproductive Health Services for Women and Girls Project (E2A) is USAID’s global flagship for strengthening family planning and reproductive health service delivery. The project aims to address the reproductive healthcare needs of girls, women, and underserved communities around the world by increasing support, building evidence, and facilitating the scale-up of best practices that improve family planning services.

Awarded in September 2011, this project will continue for eight years, until September 2019. The project is led by Pathfinder International, in partnership with ExpandNet, IntraHealth International, Management Sciences for Health, and PATH.

Introduction

In 2014, Nigeria’s National Council on Health approved a task-sharing policy that permits Community Health Extension Workers (CHEWs) to offer all contraceptive methods, except for surgical methods at health facilities. Despite this significant step toward maximizing the use of existing human resources in health to increase Nigerians’ access to a range of effective contraceptive methods, there has been little progress toward Nigerian states operationalizing this policy change. Generating evidence related to task-sharing to guide state-level adoption and operationalization will be integral to putting the new laws into action.

The Evidence to Action (E2A) Project supported efforts to operationalize the national task-sharing policy in Nigeria by generating evidence that shows how the policy can be applied at the state level to meet unmet demand for contraception. Part of this effort included working with the Akwa Ibom State Ministry of Health (SMOH), from November 2015–December 2016, to train CHEWs in two Local Government Areas (LGAs) to provide

contraceptive uptake as previously provided by nurses or midwives (see the policy brief Building Evidence to Support the Provision of Implants at Community Level through Task-Sharing).

E2A presents evidence in this technical brief and the operations research study to inform the adoption of the national task-sharing policy in Akwa Ibom and additional Nigerian states. Findings from the task-sharing interventions described in this brief indicate that building the capacity of CHEWs to offer injectables and implants—when coupled with targeted demand-creation activities that include information and counseling on these methods—can contribute to increased access to a wide range of contraceptive options at health facilities and in communities. The evidence will enrich the ongoing dialogue about the role of CHEWs in reducing unmet need for family planning services, increasing contraceptive use, and how various states and LGAs can operationalize the policy in the way that it best serves local populations' family planning needs.

In addition to providing implants and injectables, E2A engaged CHEWs to simultaneously support interventions in the two LGAs of Akwa Ibom that focused on young women, especially first-time mothers. This helped to both increase their demand for and access to integrated family planning/sexual and reproductive health/maternal and child health services. The interventions for first-time mothers are documented in a separate technical brief (Increasing Access to Contraceptive Information and Services for First-Time Mothers in Akwa Ibom, Nigeria).

Context

Akwa Ibom State Indicators²

Contraceptive prevalence rate, modern methods, married women 15-49: 16.5%

Unmet need for contraception, all women 15-49: 18.6%

Total fertility rate: 3.9

Women's use of modern contraception in Nigeria is still quite limited. The results of the 2013 Nigeria Demographic and Health Survey (NDHS) showed that only 10 percent of currently married women were using modern methods of contraception, with significant variations across the zones: 12.4 percent (North Central); 2.7 percent (North East); 3.6 percent (North West); 10.0 percent (South East); 16.4 percent (South South, the zone in which Akwa Ibom State is located); and 24.9 percent (South West). Like the 2008 NDHS results, the 2013 NDHS results showed that when women have access to a range of contraceptive methods, they tend to choose injectable contraceptives most often.²

Nigeria's national task-sharing policy, passed in 2014 by the National Council on Health, presents an opportunity for increasing contraceptive uptake among populations where contraceptive use is limited by enabling CHEWs to offer a range of contraceptives including injectables and implants. Building the capacity of CHEWs in this area is critical to Nigeria meeting its national and international family planning commitments. This is particularly in places like Akwa Ibom, where there is a prevailing shortage and mal-distribution of higher level health staff, and significant geographic and financial access challenges to facility-based services in most settings.

Design

E2A collaborated closely with Pathfinder International/Nigeria, SMOH, Local Government Service Commission, LGA health authorities in Ikot Abasi and Eket, and Society for Family Health (a local NGO) to ensure the task-sharing interventions were designed to meet local family planning needs in the two LGAs of Akwa Ibom. For example, E2A/Pathfinder Nigeria engaged with LGA health authorities, community gatekeepers, and men's groups to build demand for and acceptance of family planning in target LGAs. The task-sharing interventions were designed to increase access to a range of contraceptive methods, to strengthen referral systems, and improve quality of care

and organization of family planning services.

Working with SMOH and LGA health authorities, E2A assessed the readiness of 14 health facilities (seven from Ikot Abasi and seven from Eket) to provide quality family planning services. The assessment focused on elements including: when and what types of family planning and sexual and reproductive health services were offered; availability and capacity of staff to provide these services; family planning client load; types of demand-creation activities conducted; equipment, supplies, and commodities available; cost of family planning services; and types of youth-friendly services offered.

E2A interviewed 22 CHEWs from the facilities about their capacity to provide family planning services, and particularly to add the provision of injectables and implants to their tasks through community-based outreaches and facility-based services. The assessment involved data extraction from the HMIS and interviews with CHEWs, their managers, and a few clients. Eligibility criteria for selection of CHEWs included: being a senior CHEW (not junior CHEW), some previous training on family planning, and working in the family planning unit of a health facility or providing support to a family planning unit.

The assessment identified the following gaps and opportunities for delivering facility- and community-based family planning services, including provision of injectables and implants:

- All facilities provide family planning services, with contraception largely limited to condoms, oral pills, and injectables.
- Two CHEWs had some form of in-service training for family planning (3-day workshop), while others were untrained.
- All CHEWs required additional family planning training, including sessions on provision of injectable contraceptives and implants.

Based on the assessment, in September 2015, E2A, Akwa Ibom SMOH, and LGA health authorities selected 10 health facilities and

their catchment areas for implementation of the task-sharing interventions, and identified and trained 15 CHEWs to counsel on a full range of contraceptive methods. They provided an expanded mix of methods, including injectable contraceptives and implants, and referred for IUCDs and permanent methods.

E2A conducted the following activities to address capacity gaps identified during the assessment:

- Training to improve CHEWs' capacities' in family planning counseling and provision of methods, including injectable contraceptives and implants;
- Strengthening supportive supervision;
- Strengthening commodity logistics and HMIS; and
- Implementing concurrent demand-generation strategies.

Implementation

Family planning training

In November 2015, E2A conducted a two-week competency-based family planning training for the 15 CHEWs, using the national long-acting reversible contraception (LARC) training manuals for CHEWs, centered on family planning counseling and provision of all family planning methods except permanent methods and IUCDs. Trainings included competencies in both inserting and removing implants, offering injectables, and improving knowledge and provision of short-acting contraceptives and family planning counseling that honors voluntary informed choice. The trainings also included sessions on:

- Role of CHEWs in family planning service delivery;
- Human reproduction;
- Interpersonal communication and counseling;
- STIs/HIV/AIDS;
- Dual protection;
- Service quality;
- Record keeping (including NHMIS

record forms);

- Commodity Logistics management; and
- One-day supplemental module on youth-friendly services, including a focus on how to conduct home visits with first-time mothers.

The training included a one-week pedagogical phase (classroom-based learning) and a one-week practicum phase, facilitated by SMOH Master Trainers. CHEWs were asked to conduct a pre- and post-test during the pedagogical phase. Only those who demonstrated sufficient competencies, using anatomical models, progressed to the practicum phase. A post-training competency assessment was conducted within three months after the practicum phase. Only those CHEWs who demonstrated sufficient competencies were certified. CHEWs provided implants and injectables during this three-month post-training period and benefited from regular supportive supervision.

Strengthening supportive supervision

For the next 10 months after the training, the CHEWs received continuous supportive supervision from E2A and the SMOH, until September 2016. In partnership with the Akwa Ibom SMOH, E2A conducted regular supportive supervision visits to all trained CHEWs to ensure the quality of family planning service delivery (at facilities and in communities), including a focus on youth-friendly approaches to service delivery. E2A also joined CHEWs for quarterly review and exchange meetings at the Pathfinder office, and provided technical assistance to document the implementation processes and guided CHEWs to plan and conduct demand-creation activities.

By strengthening commodity logistics and HMIS, E2A provided continuous support to the SMOH in the "last mile" distribution of family planning commodities from the central store in the state capital. This included: review and resupply meeting with LGA Family Planning Managers and

Facilities' Family Planning Focal Points, and review of family planning consumption data. Commodities were supplied depending on each facility's consumption pattern. For evidence generation and good monitoring practices, E2A also built CHEWs' capacities in record keeping, data collection, and reporting.

Implementing demand-generation strategies

CHEWs participated in periodic demand-generation and service-delivery outreaches to provide integrated services—which included home visits. For home visits, they deliberately targeted young couples, especially first-time mothers, focusing on healthy timing and spacing of pregnancies (HTSP) counseling. Outreach activities included counseling on all methods and referrals to services during outreach or at the 10 supported facilities. Community-based distributors working with the local NGO, Society for Family Health, were also engaged to support CHEWs in making these referrals.

In addition to home visits, CHEWs conducted periodic group health talks with young leaders, meetings with Village Chiefs or Village Committee Members, outreach visits to brothels (in Idung Iniang) to hold talks with sex workers, and women's health talks at church. Each CHEW conducted different types of demand-generation activities at different times. In other words, there was no systematic approach to outreach and demand creation activities.

In Ikot Abasi, Society for Family Health also conducted a six-month social marketing campaign, engaging existing interpersonal communication agents in demand creation for family planning, with a focus on LARC. CHEWs in Ikot Abasi could therefore leverage these demand-creation efforts.

The project was originally designed to leverage the sensitization and outreach activities of community-based organizations funded through a PEPFAR-supported private sector PMTCT project that was implemented by E2A. However, new

guidelines were released at the early stages of the project, which prevented use of PEPFAR funds in the two intervention LGAs. Although E2A shifted its strategy to provide additional support to CHEWs to conduct community outreach activities, more than half of the facilities had very few health providers (e.g., only one nurse/midwife and one or two CHEWs). Thus, CHEWs were often unable to take time away from facilities to implement their community outreach activities.

Monitoring, evaluation and documentation

At the inception of the project, a baseline survey was conducted to assess the readiness and capacity of CHEWs to provide family planning services. E2A and SMOH continuously monitored interventions during regular visits following the two-week competency-based training. Following the project's termination, in December 2016, an endline assessment was conducted to determine the effect of the 13-month intervention in Eket and Ikot Abasi LGAs (from the viewpoint of CHEWs and facility managers). A total of 15 key informant interviews (KIIs) with facility managers (8 in Eket and 7 in Ikot Abasi) and 2 focus group discussions (FGDs) with CHEWs (1 in each LGA) were conducted. Of the 15 CHEWs trained, 13 took part in the FGDs. To ensure responses were appropriately captured, cell phones and tape recorders captured all conversations.

Data were collected using FGD and KII guides specific to the target respondents. Both guides assessed the same result areas:

- Improvement in capacity of CHEWs to provide family planning services;
- Increased family planning uptake;
- Creation of an enabling environment for provision of family planning services; and
- Contribution to the global evidence base on effective strategies to reach first-time mothers.

Results

During discussions and interviews with facility managers and CHEWs, individuals expressed that they had observed an increase in uptake of family planning services in the two LGAs. Most respondents said they had more clients during the intervention period as compared to the pre-intervention period. They pointed toward demand-generation activities, including home visits, as the main driver for the increased uptake of services. CHEWs stressed that many misconceptions about family planning perceived by members of the communities had been corrected by CHEWs and other service providers.

CHEWs from the two LGAs said the two-week training and continuous supportive supervision improved their performance in family planning service provision. However, most of the CHEWs said they still require training on implant removals, as there were no clients wanting implant removals after the initial training. Managers also said there had been improvement in documentation in terms of quality, timeliness, and accuracy.

Capacity of CHEWs to provide family planning services

CHEWs said the trainings had a positive impact on provision of family planning services in the facility and community. All 15 CHEWs were certified by SMOH to provide family planning services, including implants and injectables.

“What helped me to carry out family planning services you know, smoothly in my facility and community is...the training we received from Pathfinder, that has helped me to know how to talk to people, explain things to them, you give them correct information about family planning. But before now, people were having the wrong information about family planning.”

“The family planning that we have trained on has affected the services in the health facility and the community so much, because when we were not trained, we as CHEW we were not allowed to render family planning. But since we have trained, we have been allowed to render the services in the health facility and also in the

community.”

All the CHEWs rated their current capacity to provide family planning services as being very good.

“My capacity is very good. Since I started inserting implants after the training, I don't have any problem.”

“I have done two removals. One person came all the way from Abuja, then the other person came from another state. She came and I carried out the removal successfully. To insert is very easy, unlike before.”

Most CHEWs from Ikot Abasi said they did not face any barriers to the provision of family planning services, although previously misconceptions about family planning were prevalent in their communities. CHEWs from Eket said financial constraints and lack of equipment (e.g., sphygmomanometers) made it hard to offer services in hard-to-reach areas.

“I don't have any barrier both in the health facility and in the community, and to be frank, the first person that I gave implant, she came together with her husband when I went to the house, when I do the home visiting I talked to them and they understand, in fact the husband trust the wife, that was the first implant I did. Both the wife and the husband they come together, so I don't have any barrier.” (CHEW, Ikot Abasi).

“The barriers and the constraint is finance; we need our government to support us financially, so that we will be able to reach those we were not able to reach, so that they will accept the method they have already told us they are going to accept. Because so many of them are in very interior area. We need to transport ourselves, hire a bike to go and meet them in their house and to also create awareness. We still have a lot to do concerning mobilization, we have not even started, a lot of work is still there for us, so we need support from our government.” (CHEW, Eket)

Regarding the need for further capacity building, all CHEWs said they need more capacity building, specifically in removal of implants and IUCDs.

Figure 1. Number of commodities distributed by CHEWs

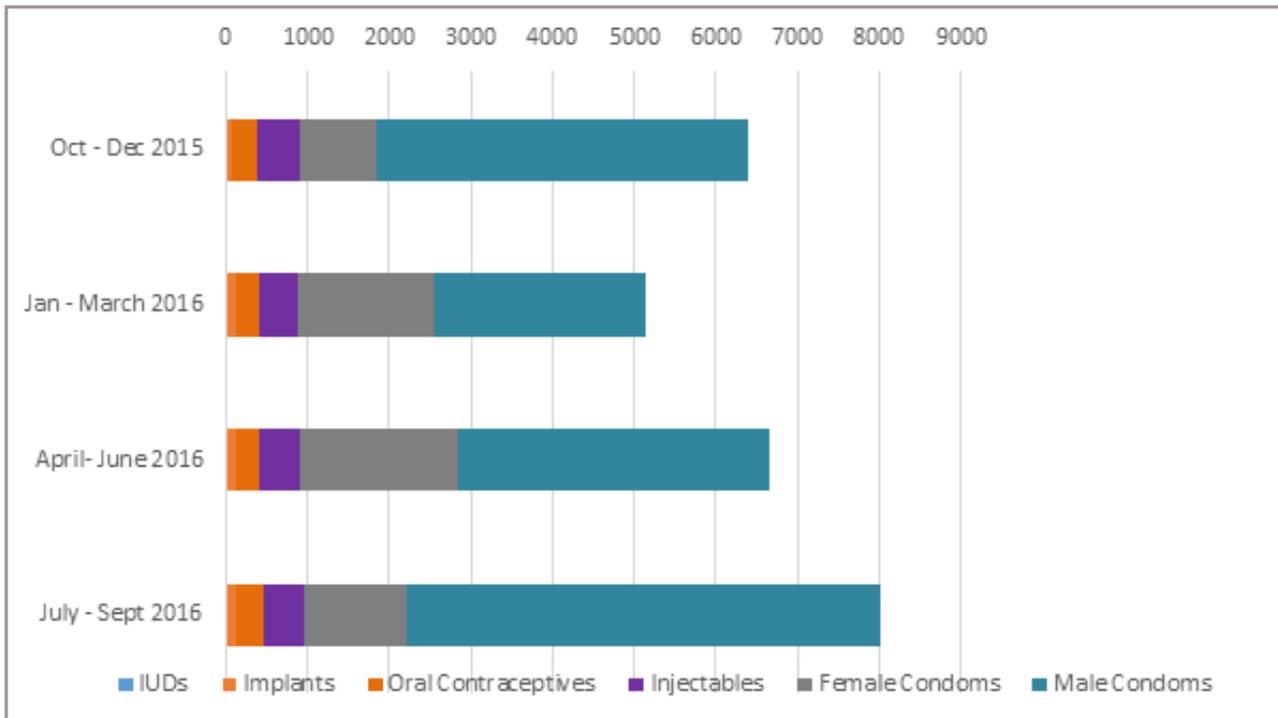


Figure 1 shows the number of commodities provided by CHEWs over the course of the activity. The 15 trained CHEWs provided 406 implants and 1,989 Injectables. The number of implants provided increased over time (from 57 Oct-Dec 2015 to 120 July-Sept 2016).

Figure 2. Alignment of CYP and community members reached through outreach

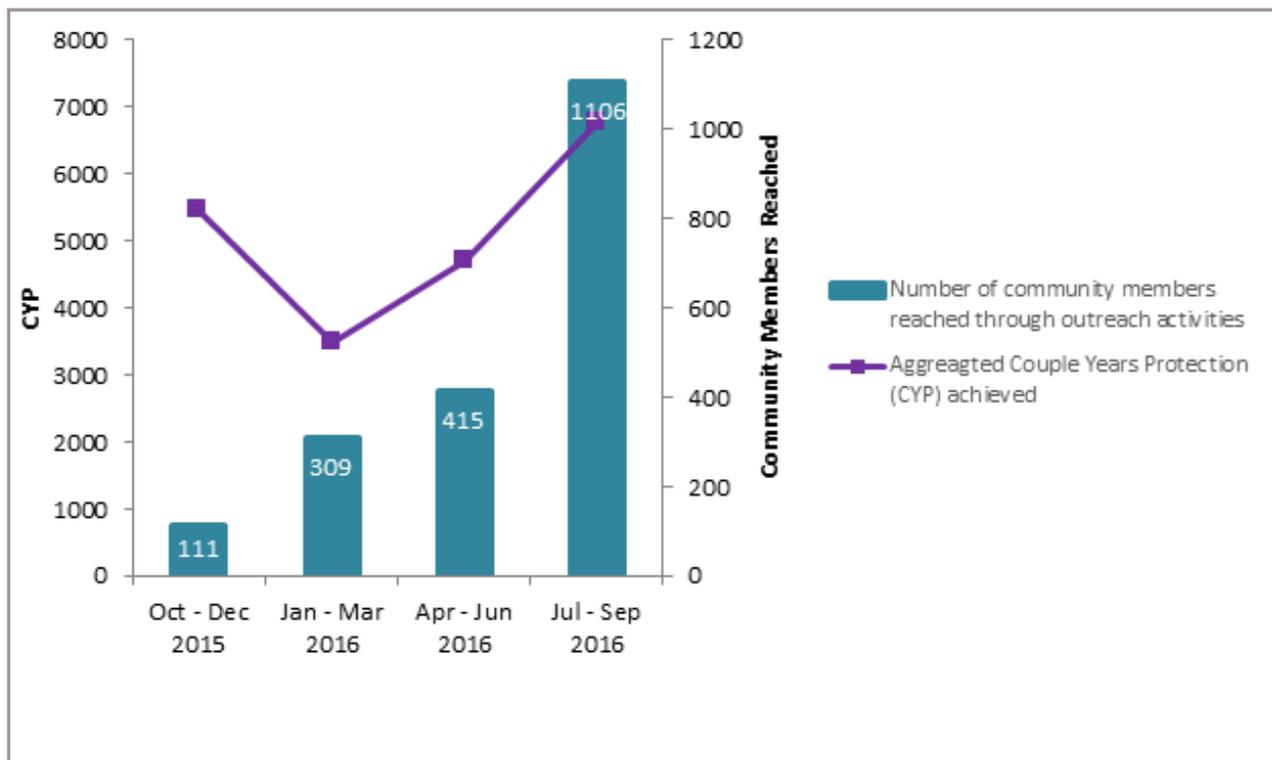
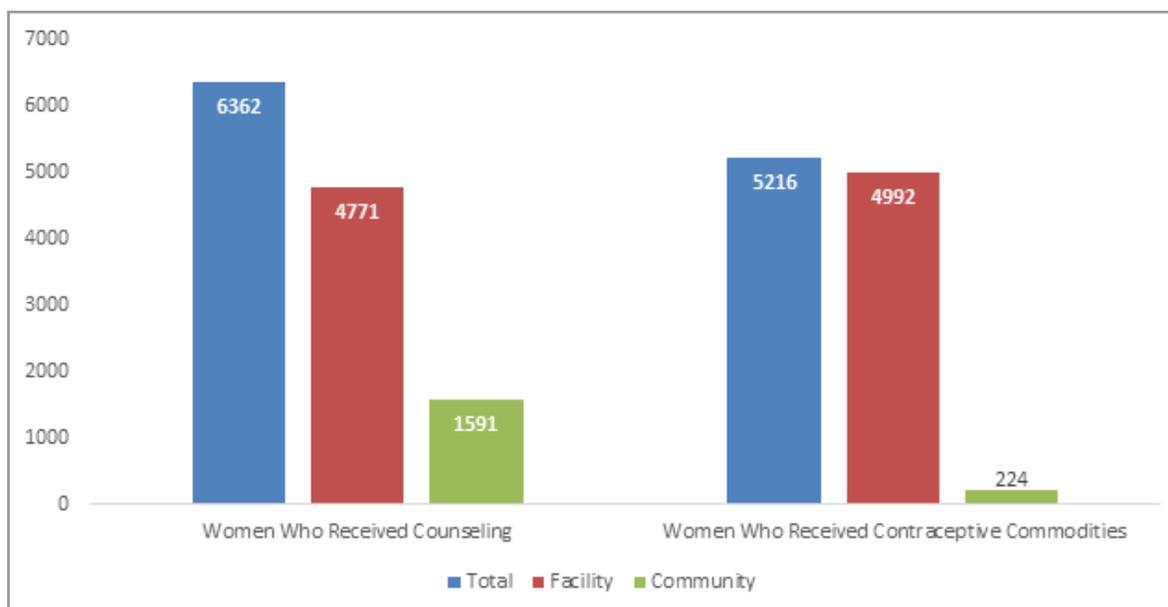


Figure 2 shows the trend between number of community outreach activities conducted, number of people reached through outreach activities, and Couple Years Protection (CYP) per quarter. As the program progressed, and more people were reached through outreach activities, CYP tended to increase.

Figure 3. Women of reproductive age who received family planning services by trained CHEWs, by service delivery point



*Note figure above does not represent a count of unique women, but includes repeat visits and clients

Figure 3 indicates the number of women who received family planning services (counseling and commodities) from trained CHEWs by the service delivery point (community and facility). A total of 6,362 women received counseling. Most counseling visits took place in the health facility. In addition, 5,216 women received family planning commodities from trained CHEWs. This value includes both new and repeat clients. Most women received family planning services at facilities. All 224 women who received commodities in the community were new users.

“I think that if at all there will be another type of training that the federal government will carry out again, I think that we need to be trained upon. Like we are not trained on IUCD, and (Continued from page 4)

am thinking that the government should train us again for IUCD, because we are very much happy to be inserting implant and we want also to know how to insert IUCD.”

Demand for and uptake of family planning services

Most CHEWs said home visits, talking to clients during immunization sessions, and creating awareness about family planning through outreaches helped to increase uptake of both facility- and community-based family planning services.

“When we went out for outreaches maybe for family planning; we go out, discuss the importance of family planning, the benefits. That is how they will come from community to the health center, some we give them outside there.”

“When we went out to immunization outreaches, we talk about family planning, that we have been providing family planning services. The client coming out for immunization session will hear it and the people that like it will come over to us. Some immediately there, after injecting them for immunization, they will come over and ask us about family planning. If it is an implant, we will tell them to come over to the center and if it is an injectable, because we have told to be carrying out injectable when we going to outreach, we will provide it there.”

Enabling environment for provision of services

All respondents said that there has been a change in community attitudes, and family planning is now accepted.

“With the correct information that they have gotten now about family planning, the benefit of family planning and community, the people really appreciate it.”

“There is a great change ever since we started

providing family planning services to our client and people in our community because of us. We are able to rule out the misconception that people have about family planning knowing it well that all those things were fake. They are really thanking the health workers and appreciating our effort.”

Regarding the attitude of community leaders, some of the CHEWs said previously they were resistant to family planning due to myths and misconceptions. However, almost all CHEWs said attitudes among community leaders had changed, and some of them bring their wives for services.

“Same to them... the old women are now accepting it. They are encouraging their maybe daughter-in-laws, some of them. Because through the explanation from the provider they now accept.”

CHEWs conducted community outreach events to provide information and counseling on all family planning methods along with referrals to supported facilities. 1,941 community members participated in

outreach activities, including 1,176 women over the age of 10 and 765 men.

CHEWs conducted home visits to provide HTSP counseling and services. A total of 710 women were reached. Table 1, below, shows the age breakdown of those women.

Lessons Learned and Recommendations

Continue capacity building for CHEWs, particularly in implant removals and delivery of community-based family planning services.

Although the competency-based family planning training helped to increase CHEWs' capacity to provide implant and injectable services, many still lack confidence in offering implant services, especially removals. Supportive supervision should focus on continuous capacity building to offer implant services. To date, efforts to operationalize the national task-sharing policy have focused primarily on building CHEWs' capacity to offer injectable and implant services at the facility level. Currently, all CHEWs have experience offering short-acting methods at facilities, but most have little to no experience offering injectables in community settings. Extending access to these services at the community level via CHEWs has the potential to further increase uptake of contraceptive service, and reduce unmet need. Additional capacity building will be required to introduce strategies to offer an expanded range of contraceptive services at the community level.

Expand the health workforce at supported facilities and beyond.

For CHEWs to effectively deliver family planning counseling and services both at facilities and in communities, the government must more fully staff the supported health facilities. Because CHEWs spent so much of their time at facilities, this limited their ability to provide community-based services and engage in demand-generation efforts. The government should also offer refresher training for the facility managers so they

can supervise the providers well. CHEWs in other LGAs should also be trained to expand the benefits of the interventions to other areas of state.

Leverage the work of existing CBOs in demand generation.

Although awareness on family planning seemed to increase in the intervention areas, there is need for continuous investment in demand-creation and outreach interventions to increase and sustain community acceptance of family planning. Further scale-up of task-sharing via CHEWs should include the engagement of trained community referral agents and CBOs to conduct community-based demand creation activities. The collaboration with the Society for Family Health in this project showed that these referral agents can support CHEWs with demand-generation activities. The government should follow up with the trained CHEWs by continuously monitoring and empowering them to continue with demand-creation activities to sustain the impact of the intervention.

Advocate for adoption of national task-sharing policy at state level.

The approach used to task-share provision of injectables and implants with CHEWs described in this technical brief shows potential to increase access to a full range of contraceptive options in Akwa Ibom. The evidence presented here, including key lessons such as the need for further capacity building and demand-creation activities, can be used to inform advocacy for adoption of the national task-sharing policy in Akwa Ibom state and other Nigerian states. When considering adoption and operationalization of the national law, evidence in this brief should be analyzed along with evidence from more rigorous task-sharing study conducted by E2A in Cross Rivers and Kaduna states.

Conclusion

Findings from the task-sharing interventions described in this brief indicate that building the capacity of CHEWs to offer injectables and implants—when coupled

with targeted demand-creation activities that include information and counseling on these methods—can contribute to increased access to a wide range of contraceptive options at health facilities and in communities. As a result of demand-creation activities, including home visits and outreach conducted by CHEWs with CBOs, awareness of family planning services and referrals for services have increased, and misconceptions about family planning among some gatekeepers and community members have been waning.

Findings indicate that CHEWs are effectively providing family planning services at facilities and in communities. However, the impact of the intervention needs to be sustained as the respondents had mentioned that the gains were made due to their committed effort to conduct demand-creation activities. The government should support CHEWs to continue providing services, while mobilizing other NGOs to integrate family planning services in their programs, engaging referral agents through CBOs to conduct demand-generation activities, and expanding the skilled health workforce capable of providing a full range of contraceptive methods at health facilities. These efforts will contribute to operationalization of the national task-sharing policy at state level.

Citations

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2. National Population Commission (NPC) [Nigeria] and ICF International. 2014. Nigeria Demographic and Health Survey 2013. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF International.



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