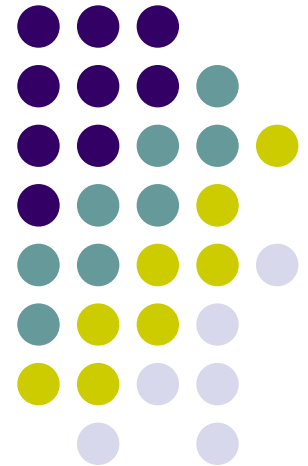


Community-Based Access to Injectables: Policy Changes around Task Sharing

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Outline



- Rationale for expanding community-based access to injectable contraception
- Background of community-based distribution of injectable contraception in Africa
- The Road to Policy Change
 - Uganda, Madagascar, and Malawi
- Conclusions and Recommendations

The Rationale for Expanding Community-based Access to Injectable Contraception



- Evidence-based strategy: effective, safe and feasible
- Expands access beyond health facilities to reach underserved populations (rural and urban)
- Alleviates some of the burden on declining numbers of professional health care providers
- Increasing access to DMPA has increased CPR at the national level
- Fits within the WHO Task Shifting Framework
- MDGs and country-specific FP and other health goals cannot be met without increasing access to FP

WHO Technical Consultation on Expanding Access to Injectable Contraception

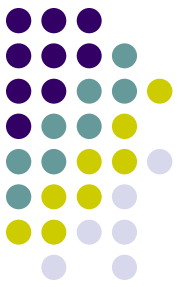


In June 2009, 30 technical and program experts convened at the World Health Organization in Geneva

Consensus Statement

“There is sufficient evidence to support the introduction, continuation, and scale-up of community-based provision of progestin-only injectable contraception.”

Community-based distribution of injectable contraception in Africa



- Began in sub-Saharan Africa following more than three decades of implementation experience in Asia and Latin America
- In 2003, the Ministry of Health of Uganda agreed to conduct a pilot test. Results of the pilot test demonstrated that community-based provision of DMPA was safe, feasible, and acceptable.
- Followed by phased scale-up in Uganda and uptake in other countries

The Uganda Experience

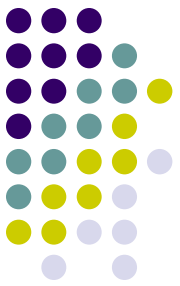


- 2004-2005 pilot study conducted by Family Health International with partners Save the Children/USA, Uganda's Ministry of Health, and Nakasongola District's Local Government
- The pilot study confirmed findings of other studies in other parts of the world; CHWs can safely and feasibly provide DMPA in settings other than clinics, and the practice is accepted by communities. This evidence, combined with the strategy's potential to increase access to injectables among women, called for a targeted scale-up of the program.
- Followed by phased scale-up in other districts



Policy Change: Uganda

- The Ministry of Health of Uganda has agreed to phased scale-up of the intervention
- NGOs are moving forward with incorporating community-based provision of DMPA into their programs.
- Policies in Uganda with regard to community provision of DMPA remain unchanged



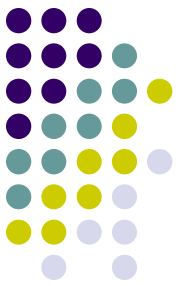
The Madagascar Experience

- In 2006, the Ministry of Health, Family Health International, and other partners initiated a pilot in two regions.
- Madagascar followed these pilot studies with national scale-up.
- As of April 2009, 448 CHWs received training, 44 staff members of 16 NGOs were trained in supervision skills, and 4,190 clients had been reached with DMPA services.

Policy Change: Madagascar

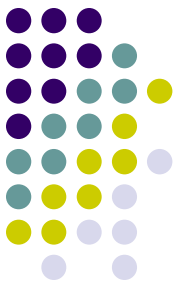


- In 2006, the Madagascar Ministry of Health developed a new set of Ministry *Standards and Procedures*, which includes support for community-based distribution of injectable contraception.



The Malawi Experience

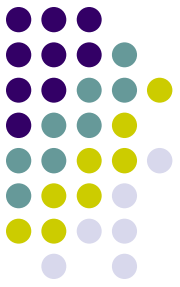
- In Malawi, there are two potential cadres of workers that could provide DMPA:
 - Health Surveillance Assistants (HSA): lowest level of civil servant in the public health system. They are based in communities and work in mobile or outreach clinics, village clinics, or health posts
 - Community-based Distribution Agents (CBDAs): volunteers selected by and based in their communities to provide FP counseling, oral contraceptives, and condoms.



Policy Change: Malawi

- Following years of debate, the policy was changed in 2008 to allow Health Surveillance Assistants to administer DMPA.
- An evaluation study is being conducted to determine the feasibility of provision of DMPA by CBDAs and an assessment is being done on HSA provision of DMPA to inform the Ministry of Health on potential scale-up and provide recommendations

Challenges to Policy Change

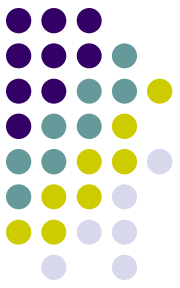


- Resistance by medical professional communities
- Perceived expense of community-based programs
- Concerns over safety
- Concerns over the potential burden of adding another FP method to an existing community-based distribution program

Strategies for Overcoming Challenges



- Utilize a champion in the MOH
- Conduct targeted advocacy efforts
- High-level policy decision-making using evidence
- Implement demonstration projects
- Development of operational policy and guidelines



Conclusions

- An influential champion can be instrumental in ensuring effective advocacy efforts
- Strong evidence can help advance uptake and address concerns
- Support from the medical and political community is important
- Open communications, identify obstacles, and develop solutions