Fostering Change for Scale-Up of Good Practices in the WAHO Region

A Pre-Forum Workshop for the First ECOWAS Forum on Good Practices in Health

July 28, 2015
Ouagadougou, Burkina Faso

Workshop Report

Contents

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Executive Summary

More than 100 Ministry of Health focal points and officials and NGO partners from across West Africa became familiar with tools and approaches they can use to systematically scale up effective practices in maternal health, reproductive health/family planning, and adolescent/youth sexual and reproductive health at a one-day workshop in Ouagadougou, Burkina Faso.

The workshop set the stage for the first Economic Community of West African States (ECOWAS) Forum on Good Practices in Health, where more than 300 Ministry of Health, civil society and other partner representatives from the ECOWAS region explored good practices in leadership, management, and governance; sociocultural approaches and advocacy; and scale-up and sustainability.

The workshop was designed to provide concepts on scaling up as well as hands-on skills building, which would provide a basis for analyzing practices highlighted during the forum itself. The workshop specifically sought to meet the following learning objectives:

a. To identify and describe key components of the scale-up process for effective practices and programs.
b. To apply aspects of the change/scale-up process to specific issues and practices for reproductive health and youth and maternal and newborn health.
c. To identify actions after the workshop that will support scale-up efforts in a particular context.

The workshop consisted of two sessions on the importance of systematic scale-up and the principles of scaling up, followed by a panel on six successful examples of scaling up. A modified Knowledge Café presented information on various tools for scaling up. Finally, participants engaged in a group work session to gain practical experience applying systematic approaches to scale-up, using case studies from the field.

Welcome and Introductions

Namoudou Keita, Primary Health Care Professional, WAHO, opened the workshop by welcoming the participants to the day of knowledge exchange. He and Salwa Bitar, Senior Advisor for Scale-Up for the USAID-funded E2A Project, explained the link and synergies with the ECOWAS Forum and emphasized that the workshop would focus on scale-up and the change process. They explained that scaling up good practices is challenged by people who are resistant to change, and when the process of scale-up or change is not well-understood. They hoped that the workshop would present tips and tools for participants to foster change in their respective countries. An overview of meeting objectives was given.

Xavier Crespin, WAHO Director General, thanked the workshop participants for turning up in such high numbers to attend the workshop (the initial estimate of attendees had been about 50). "An array of good practices and projects in pilot phases for maternal, newborn and child health exist in our region, but they remain largely unknown by the wider public. This workshop is an opportunity for us to showcase what we are capable of," he said. According to Dr. Crespin, examples of good practices should be identified and disseminated so that countries in the ECOWAS region can adopt and scale them up to improve health.

Meeting Sessions

Opening Session: Vision and Strategies for Scaling up FP/RH and MNCH Services

Sheila Mensah, Senior Communications, Monitoring and Evaluation Advisor for USAID/West Africa Regional Health Office, presented USAID's expectations for partners and ministries scaling up maternal, neonatal, child (MNCH), reproductive health (RH), and family planning (FP) interventions. She described USAID's two key initiatives, An AIDS-Free Generation and Ending Preventable Child and Maternal Deaths, and underscored the critical role that FP and RH play in achieving those goals. She also underscored the importance of scaling up best practices. "We can end preventable child and maternal deaths but only with effective best practices," she said. She highlighted several roles that participants—government ministries—could play to accelerate scale-up, including determining and prioritizing the best practices for each specific country, providing a platform to facilitate collaboration and coordination among partners, investing in resources (financial and human) so that practices can be sustained beyond introduction, and ensuring that legal, political, and social environments are conducive to creating demand for best practices.

Ms. Mensah also described the role that partner organizations can play, including supporting national governments as they lead and own the process and harmonizing indicators and milestones. "We will succeed if everyone plays their role—if we partner and if we include the people of ECOWAS at every level of the health system."

Suzanne Reier of the World Health Organization and the IBP Secretariat then highlighted the importance of a systematic approach to scaling up. She emphasized that change is not easy, and that the *change process itself* should use evidence-based principles that have been proven to foster change. Her statement, "don't leave change to chance,"

To determine whether an innovation is ready to be scaled up, assess whether it is:
C – redible
O – bservable
R – elevant
R – elatively advantageous
E – asy to install
C – ompatible
T - estable

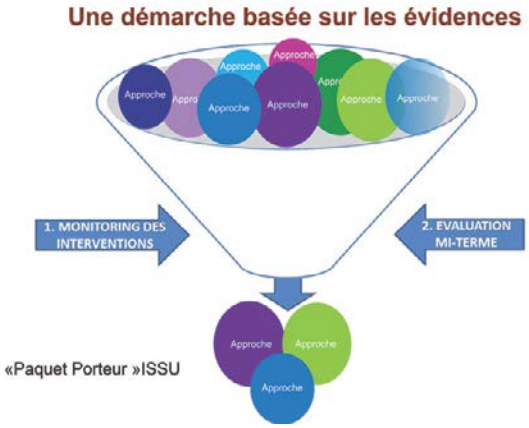
particularly resonated with participants.

Ms. Reier also led the participants through IBP's Fostering Change methodology, which is an overarching process for any scale-up approach. She listed eight evidence-based principles to ensure change happens, including making sure that those expected to make the change perceive that the change is important, and having a committed change agent and stakeholders, support from leadership, clarity about purpose, and clearly assigned and accepted roles and responsibilities. She also described the CORRECT model which helps to determine whether an innovation is ready to be scaled up as well as the phases of scaling up, and where to find tools online.

Panel Session: Country Experiences on Fostering Change for Successful Scale-up

Six successful experiences in scaling up were presented by various organizations and projects.

Senegal: ExpandNet experience with the Urban Health Initiative or Initiative Sénégalaise de Santé Urbaine (ISSU)



Youssou Diop from Intrahealth presented a project that was in the process of scaling up. His presentation focused on the process through which the project determined the final package of interventions to replicate, related to increasing the contraceptive prevalence rate. At the project's outset, numerous interventions were undertaken, but after the midterm evaluation, six interventions focusing on three key areas (necessary inputs, complementary services, and demand generation) were selected as the minimum package for further replication. He emphasized that the contribution of resources from both governments and partners is key to scaling up. "Strong involvement of the district team, in terms of both human resources as well as financial resources, is necessary for sustaining any scale up."

Liberia: Performance-based Financing (PBF) for Improving Service Quality

Joan Marshall-Missiye detailed how Management Sciences for Health (MSH) scaled up a performance-based financing approach which used monetary incentives to improve service quality and built capacity of county health teams in Liberia using a mix of contracting *in* (where one level of government contracts with another) and contracting *out* (where an external partner provides services by contracting with the government). The Ministry of Health, county health teams, facilities as well as partner NGOs decided together which indicators, when met, would constitute the basis for payment. This strategy resulted in increased motivation in recruitment, achievement of indicators (increasing service delivery), increased performance in management/supervision, and increased performance in monitoring data. For FP, the indicator used is Couple Years Protection, ensuring compliance with US Government regulations. Capacity building in PBF as an input to the program (the Ministry of Health and Social Welfare required training on overseeing a PBF program) was integral to success. The tools that became embedded and the goals of reaching indicator targets necessitated training and ensured sustainability beyond the project.

PBF was scaled up from 97 facilities to more than 250 in 12 counties. Unfortunately, since the Ebola epidemic, PBF has been scaled down to 3 of 15 counties, as the government had prioritized the Ebola response. There is a PBF community of practice in Africa.

Niger: E2A University Leadership for Change

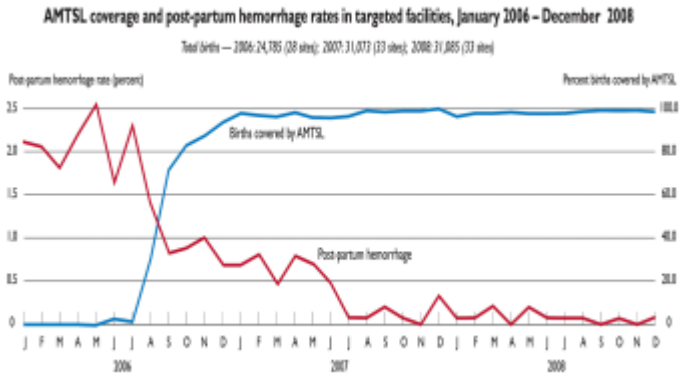
Ousseini Abdoulaye described how E2A used ExpandNet's "Beginning with the End in Mind" scale-up approach to document an intervention at Abdou Moumouni University in Niamey, Niger, to increase knowledge and use of sexual and reproductive health services among students. It is currently in the demonstration phase of the project, and Mr. Abdoulaye stressed the value of systematic collection of qualitative data to produce documentation and analysis for scale-up. Actions taken after iterative analysis of the data has demonstrated to stakeholders who are typically focused on quantitative data that qualitative information is valuable. The information will inform future planning of the intervention.

Togo: Postabortion care

Dr. Ntapi Tchiguiri described how a postabortion care intervention was scaled up both horizontally and vertically at five pilot sites to help reposition FP in Togo. The project sought to improve access to quality postabortion care-FP services, thereby increasing the use of contraception to eradicate the cycle of repeat abortions. To improve access and a quality, services were reorganized so that postabortion care was provided in a separate room for client privacy at the health facility. Providers also now provide FP counseling and services in that same room or in a room nearby where clients go directly after receiving other postabortion care services. Clients are given the choice of a range of FP methods, including long-acting reversible contraceptives. Ministry of Health support for scale-up was critical. At the facilities, it was also important to assign responsibilities and to have a team from the FP and maternity units committed to success. Capacity building, supportive supervision, and strong health management information systems were also key.

Niger and Mali: Scaling up an integrated maternal and newborn health program

Dr. Maina Boucar, Regional Director for West Africa, USAID ASSIST Project, emphasized the importance of a collaborative approach in scaling up quality MNH services. "We shouldn't continue to make the error that training is enough – training has been around for decades!" he said. Networking among facilities allowed them to combine efforts and improve quality on large-scale. Weekly site-based meetings and periodic regional meetings allowed site teams to self-assess and monitor common indicators as well as share lessons learned from other sites and promote regional problem solving for systems.



The project also followed a systematic scale-up strategy: regional/district hospitals that handle the highest volume of births were targeted first, then a two-pronged expansion strategy would 1) move down the health system to primary maternities at district level as well as 2) target new district hospitals at regional level, then down through system. Based on results in Niger, ASSIST would apply best practices and lessons learned to Mali.

Senegal: Informed Push Model

Dr. Bocar Mamadou Daff, Director of the Reproductive Health and Child Survival Unit of the Ministry of Health and Social Action, described the Informed Push distribution model for rolling out FP products to service delivery points throughout Senegal. The model was piloted in two districts (Pikine and Kaolack) in 2012 and demonstrated an immediate and robust impact: stock-outs were eliminated at service delivery points, there was a gradual increase in consumption of products, and information use for decision-making increased. The contraceptive prevalence rate also increased in both districts.

The Informed Push Model has since been scaled up to 14 regions and 1,400 service delivery points. Its integration into the Senegalese logistics system and planning for sustainability is underway.

There were many elements that contributed to the success of this intervention, but the commitment of the Ministry of Health and Social Action to FP at both national and operational levels was fundamental to its success.

The following lessons learned and recommendations emerged from the six presentations:

- *Teamwork, partnerships, and collaboration:* All those who have a stake in the innovation being scaled up should be oriented on the process of scaling up and be involved from the very beginning. This includes government representatives, non-governmental partners, donors, facility managers, providers, supervisors, community leaders, and communities themselves. Collaboration leads to strengthened relationships, exchange of ideas, and enhanced ownership of the innovation and the process.
- *Deliberate planning:* Whether through a phased introduction of focused interventions, or starting with a simple intervention package to generate rapid results with the intent of increasing its complexity, scale-up efforts should begin with the end in mind and implementers should detail the manner in which the end will be achieved.
- *Flexibility, creativity, resourcefulness:* Even though a plan may be specified, implementers should expect deviations from the plan and apply creative adaptations to the original strategy.
- *Capacity building*: Capacity building in the process of scale-up and change management is just as important as capacity building in the innovation itself.
- *Value of qualitative data*: This type of information elucidates the change process and informs how to implement future activities.
- *Stakeholder support and financing*: Gaining national consensus among stakeholders for the interventions being scaled and building strong stakeholder relationships is integral to success. Financing from both governments and donors will contribute to sustainability.

Modified Knowledge Café: Tools for Scaling Up[1]

Costing Tools

Colin Gilmartin of MSH described the importance of costing

[1] This session was originally designed to be several stations where participants would rotate in 15-minute increments. However, the unexpected high number of participants compelled workshop organizers to restructure this into a panel session with time for Q&A.

when scaling up an intervention and presented MSH's costing tool for scale up. The tool is a dynamic, open-source model and has the ability to combine standard and actual costs. The tool will estimate projected costs based on current costs. More information on the spreadsheet-based tool can be found here: https://www.msh.org/resources/community-health-services-costing-tool and by contacting: fintools@msh.org.

Advocacy Tools

Brigitte Syan from the NGO *Equilibres & Populations* and representative of Advance Family Planning (AFP) in Burkina Faso described the SMART tool for advocacy. SMART is composed of nine steps and is used to encourage decision-makers (at the international, national, and local levels) to make changes in policies and increases in financial commitments to FP services. The AFP advocacy tools can be found here: http://advancefamilyplanning.org/portfolio.

Nandita Thatte, Senior Technical Advisor in USAID's Office of Population and Reproductive Health, focused on high-impact practices (HIPs) for FP and RH that need to be scaled. She described the HIP Task Team led by IBP that is mapping and documenting HIPs, and holding webinars to disseminate evidence. To support the scale-up of HIPs, she recommended enhanced support to country programs to identify and implement HIPs. Through working relationships with implementing partners, IBP Initiative, and FP2020, she said HIPs can be brought to scale. She also talked about the need to build the evidence base around implementation and scale-up of HIPs. She encouraged partners to map the HIPs they are working at www.fphighimpactpractices.org.

Group Work: Considering the Change Process

In the afternoon, workshop participants went more in-depth about applying systematic approaches to scale-up by analyzing projects described in three case studies. Participants self-selected into one of three working groups to apply the principles of Fostering Change presented in the earlier sessions. These lively discussions offered participants the opportunity to interact with those from other countries, ask questions, and further examine scaling-up themes.

Within each case study, participants were asked to describe the innovation; identify which of the four phases of Fostering Change the project was currently in; identify the CORRECT attributes of the innovation; brainstorm further actions to increase scalability of the innovation using the ExpandNet's Nine Steps tool; discuss policy, legal, regulatory, budgetary, and other health systems changes that would be needed to ensure institutionalization of the innovation; and describe the efforts that would be needed to monitor the phases of change.

The detailed descriptions of the three case studies used in the group work sessions are included in Annex 3.

Youth Case Study: Increasing youth demand and access to FP services in Togo through comprehensive sexuality education (led by International Planned Parenthood Federation)

Group members for this case study spent a majority of the time discussing the elements of the CORRECT model. Participants felt that the intervention was observable, and the baseline evaluation was pertinent to the context. The intervention was also compatible. With regard to ease of installation, there appeared to be many challenges, and it was suggested that an impact evaluation be conducted before bringing the innovation to scale. More extensive documentation of the process as well as deeper involvement of stakeholders would increase the credibility of the innovation.

In terms of which phase of the Fostering Change process the case study described, there was disagreement among group members: Francophones believed that it was in Phase II: Planning for Demonstration and Scale-Up, whereas Anglophones thought it to be in Phase III: Supporting the Demonstration.

Group members highlighted the importance of rigorous documentation, involvement of key stakeholders to develop consensus regarding scale-up, and keeping the innovation simple as lessons learned in the case study.

Maternal Health Case Study: Scaling up postpartum FP services (integrating FP with MNCH care) in Guinea (led by Jhpiego/Maternal and Child Survival Program)

This group had a rich discussion, albeit a bit tangential to the discussion questions. It began with a lively debate about the definition of "innovation." Some members felt strongly that an "innovation" was an intervention that was completely brand new, and that was recently discovered and not yet implemented beyond the pilot. For interventions that had been implemented elsewhere, but were new to a specific country or context, they preferred the term "adaptation" over "innovation." Others agreed with the IBP/Fostering Change definition of "innovation": health interventions and/or other practices that are being scaled up and are new or perceived as new in an environment. The innovation can be a single intervention or a package of interventions and includes the managerial processes that are needed for successful implementation.

Participants also differed on their assessment of the CORRECT elements. For example, some did not think that the innovation was "credible" or "easy to install." In their countries, it would be too difficult to trace the pregnant woman from the antenatal care clinic to the postnatal care clinic. Or, there could be complications around payment, since the delivery service is free, but the intrauterine device (IUD) is not. Another challenge presented was the lack of sharing of records between the various types of clinics before, during, and after delivery.

Participants, however, agreed that coordination within facilities was crucial to ensuring that records were shared and used effectively. For example, the

labor and delivery provider should be linked closely with the antenatal care service to know what the mother selected as her chosen FP method. They also agreed that donor coordination was important to ensuring wider coverage and avoiding duplication. They also acknowledged the importance of training ALL providers who may be present during labor and delivery so that there is always a provider available who knows how to insert an IUD.

Family Planning Case Study: Pilot Study on Provision of DMPA by CHWs in Sierra Leone to scale up access to modern contraceptive methods (led by Marie Stopes International)

Members of this group determined that the intervention met *most* of the CORRECT criteria; it was credible (based on sound evidence), observable (users saw the results in practice), relevant (serving unmet need for population in hard-to-reach areas), relatively advantageous (improved existing practices), and testable. However, it was unclear whether the intervention was evidently compatible.

The intervention is between the third and fourth phases of fostering change. The innovation demonstration has been accomplished, and now MSI is planning for scale with successful change efforts. Given the phase the intervention is in, the Principle of Change that will be especially important to consider is motivating and supporting staff throughout the change process which will help maintain their dedication and create a support network to the change agent.

Group members also determined that this intervention was an example of "task sharing": CHWs were already providing services, and staff at the Primary Health Unit continued to provide DMPA.

To monitor the success of change efforts, group members suggested including corresponding indicators that measure how well you are doing in achieving the goals. These indicators do not necessarily have to be related to women accepting services; for example, they can address the number of districts where the intervention is implemented.

Since funding has stopped for this activity, CHWs no longer provide DMPA at the community level; they continue to assist staff working at the Primary Health Unit level (but not providing DMPA). Also, while the results of the pilot have been taken to the government for consideration of scale-up, the Ebola epidemic has diverted attention and taken priority.

Meeting Evaluation Summary

Feedback regarding the workshop was solicited at the end of the day, via email, and via questionnaires handed out to participants during the ECOWAS Forum.

Many participants cited the statement, "do not leave change to chance," as something they had learned during the workshop. They realized the importance of deliberate efforts and partnerships to ensure effective practices are taken scale. "We have to be observant and deliberate to see the change," one participant wrote. Many also stated that they had learned that scaling up had different phases which need to be considered when planning the intervention. Others cited the CORRECT characteristics of the innovation that are necessary for scale-up; several also mentioned the importance of cost and financing to ensure sustainability.

The workshop helped place participants in the mindset of having an eye toward scale-up and the principles of scale-up while attending the ECOWAS Forum. "I will be assessing the best practices to consider the stages of each and will be on the lookout for good innovative practices," said one participant. "I hope to learn more on scaling up from the rest of the Forum with examples of best practices from other countries," stated another.

Participants gave a range of responses regarding an action they planned to take upon returning to their home country. Many stated that they would review the materials presented and compare interventions being implemented against the principles of scale-up strategies. Another common action item was to share tools and materials from the workshop with their colleagues and disseminate the learnings from the day. Many also stated that they would engage in advocacy efforts (and use the SMART approach) with their ministries of health to ensure that good practices were being scaled up.

Conclusion

The workshop on scale up was a well-received opportunity for participants to learn about systematic approaches to taking effective health practices to scale, leading up to the ECOWAS Forum. They benefitted from hearing examples from the region of successful scale up, and applying tools to real case studies for hands-on experience in planning for scale up. Some key takeaways that participants reported included:

1. Scaling up is defined as deliberate efforts to increase the impact of successfully tested health innovations so as to benefit more people and to foster policy and program development on a lasting basis.
2. Don’t leave change to chance! Systematically planning for scale-up will offer you the best chance of success!
3. Realizing that scale-up is not "business as usual" and NOT routine management, is key. Sticking with the process and making sure you're monitoring and adjusting along the way will ensure sustainable scale-up.
4. Fostering Change for Scale-up is based on 8 principles of change with the first one, perhaps, being the most important: Change must matter to those making the change.

Annex 1: Agenda

AGENDA: Fostering change for scale-up of good practices in the WAHO region

Tuesday July 28, 2015
8:00 am – 5:15 pm
Palace Hotel, Room B

Learning Objectives:
a. To identify and describe key components of the scale-up process for effective practices and programs
b. To apply aspects of the change/scale-up process to specific issues and practices for reproductive health and youth and MNCH
c. To identify actions after the workshop that will support scale-up efforts in a particular context.

8:00am - 8:30am	**Registration**
8:30am – 8:45am	**Welcome and Expectations** • Salwa Bitar and Namoudou Keita
8:45am – 9:30am	**Vision and Strategies for Scaling up FP/RH and MNCH services** • USAID's expectations for partners and Ministries for scaling up (10min) - Sheila Mensah, USAID West Africa • Scaling up methodologies and the importance of a systematic approach (15 min) - Suzanne Reier • Overview of the agenda (5 min) - Sarah Bittman
9:30am – 9:45am	***Break***
9:45am – 12:00pm	**Panel: How to foster change for successful scale-up Country Experiences** *Moderated by Fabio Castano (5 min)* • ExpandNet experience with the Urban Health Initiative in Senegal (15 min) -Youssou Diop • MSH in Liberia with Performance Based Financing (15 min) – Joan Marshall-Missiye • E2A Niger University Leadership for Change (ULC) activity (15 min) - Ousseini Abdoulaye • PAC example from Togo (15 min) - Ntapi Tchiguiri K. Kassouta • URC country example maternal/neonatal health (15 min) – Maina Boucar • Informed Push Model (IPPM) in Senegal (15 min) – Dr. Bocar Mamadou Daff Questions (20 min)
12:00pm – 1:00pm	***Lunch***
1:00pm - 1:45pm	**Knowledge Café**

	Participants rotate to three different topics, spending 15 minutes at each. • Guide to Fostering Change - Suzanne Reier • ExpandNet tools - Salwa Bitar • Costing tools for scale up - Colin Gilmartin • The AFP SMART approach to advocacy - Brigitte Syan, Modibo Maiga, Alison Bodenheimer • High-Impact Practices (HIPs) - Nandita Thatte, Ados Velez-May
1:45pm - 2:15pm	**Case Study presentations: setting the stage for scale up** **MSI, Jhpiego/Maternal and Child Survival Program, and IPPF will present case studies on specific practices and where they are in terms of scale up- whether in demonstration phase or scale up phase (10 min each to present)** **MSI:** Scaling up access to modern contraceptive methods in Sierra Leone – A pilot study on the provision of Depot medroxyprogesterone acetate (DMPA) by Community Health Workers (CHWs) – Anna Macauley **Jhpiego/Maternal and Child Survival Program:** Scaling Up Postpartum Family Planning Services, and the Integration of Family Planning with Maternal, Newborn and Child Health Care, in Guinea – Yolande Hyjazi **IPPF:** Increasing youth demand and access to family planning services in Togo through comprehensive sexuality education – Ishmael Selassie and Adama Dicko
2:15pm – 3:15pm	**Afternoon Workshop** • Participants split into groups to plan for scale up for the three case study examples (integrated youth FP services, post-partum family planning, and task shifting for injectables) • **Small group activity: Considering the Phase of the Change Process** Participants receive a handout summarizing the case study and resources from the Guide to Fostering Change. In a facilitated group discussion led by the technical presenter and a scale-up expert, they will review the case studies and discuss the principles of change as they apply to the scenario.
3:15pm – 3:45pm	**Workshop report out**
3:45pm – 4:00 pm	***Break***
4:00pm-4:45pm	**Small Group Session (country groups)** Participants will break into their country teams to reflect on the following: • What innovation(s) [FP, maternal neonatal health, or youth] have been successfully piloted in your country that would be good candidates for scale up? Why? Pick one innovation, considering the following: o What factors are in place for successful scale up? o What challenges for scale up are in the way? • Based on today's presentations, what actions do you plan to take to strengthen change and scaling up efforts for this innovation? • ---each group will record their responses on a flipchart
4:45pm – 5:00pm	**Small Group report out** *Facilitated by Asa Cuzin-Kihl* • Highlights from select groups on discussion and recommendations
5:00pm – 5:15pm	**Wrap up and way forward** *Facilitated by Suzanne Reier* • Summary and call to action to apply learning with their teams on their own

Annex 2: Speaker Bios

Fostering Change for Scale-up of Good Practices in the WAHO Region

Preconference Biographies

Salwa Bitar is a medical doctor who has provided family planning/reproductive health/maternal, newborn and child health services in developing countries, and has been a trainer in contraceptive technology and best practices in family planning, safe motherhood, emergency obstetric care, and neonatal care. She has spent the last six years with Management Sciences for Health, currently working with the USAID-funded E2A Project as Senior Advisor for Scale-Up and previously with E2A's predecessor, Extending Service Delivery, under which she led the scale-up of family planning and maternal, newborn and child health services in Asia and Middle East. Dr. Bitar has 25 years' experience building strong connections with international partners, and has been a global leader in advocacy, dissemination, and scaling up of family planning, reproductive health, and maternal, newborn, and child health best practices, resulting in improved quality and scale-up of services in numerous African and Asian countries. Salwa currently leads facilitation of the community of practice on systematic approaches to scale-up for E2A.

Sarah Jonassen Bittman is a Technical Officer at Management Sciences for Health (MS) for the USAID-supported Leadership, Management, & Governance (LMG) Project. Sarah provides management and technical support to a portfolio of activities to strengthen organizations that provide services to vulnerable populations and persons with disabilities. Sarah focuses on technical assistance, grants management, program coordination, and communications. Before joining MSH, she worked with USAID's Office of Health, Infectious Diseases, and Nutrition in the Health Systems Division, providing programmatic and technical support to an array of health systems strengthening projects. Sarah has a BA from the George Washington University in International Affairs and Global Public Health, and a Master of Sciences from the Harvard School of Public Health in Global Health and Population.

Alison Bodenheimer is Program Officer II, Francophone Africa for Advance Family Planning (AFP). She is responsible for working with in-country partners to implement the AFP advocacy approach in the Democratic Republic of the Congo, Senegal, and Burkina Faso. Ms. Bodenheimer's background in francophone Africa includes consulting for UNICEF on a qualitative research study in Senegal, Benin and Madagascar, and designing and conducting a research study in two villages in rural Mali for Columbia University's Season Smart initiative. She has served as a freelance French interpreter for political asylum seekers from Côte d'Ivoire and Rwanda and has experience managing programs in reproductive health, family planning, and infectious diseases throughout Africa and Asia. Just prior to joining AFP, Ms. Bodenheimer consulted for Columbia University's Program on Forced Migration and Health in Amman, Jordan where she worked with UNICEF to improve monitoring and reporting of child rights violations in the region. She has a Masters of Public Health from Columbia University's Mailman School of Public Health and a Bachelor's degree from College of the Holy Cross in Psychology and French.

Maina A. Boucar, M.D., M.P.H., has vast experience in the purveyance, administration and supervision of health care programs in developing countries. He is an epidemiologist with a Master's Degree of Public Health specializing in epidemiology and population studies. As the current Director for USAID-Applying Science to Strengthen and Improve Systems Project for Francophone Africa, he advises government, agencies and NGOs on the integration of quality

improvement activities into their respective programs. He has worked in quality improvement for 20 years in many African countries and applied QI /QA in various topics including Malaria, IMCI, maternal and child, HIV/AIDS, anemia, Workforce. Prior to joining URC, he served at all levels of the health care system in his native Niger. His previous experiences as the head of local and district clinics as well as the Regional Director of Health in Tahoua provided a solid foundation for his ascent to the post of Secretary General of the Ministry of Public Health of Niger in 1993.

Dr. Fabio Castaño works with MSH as the Global Technical Lead for Family Planning and Reproductive Health (FP/RH) and as Portfolio Regional Director for Southern Africa and Latin America. He leads technical assistance on FP/RH to design, implement, and supervise service delivery strategies through MSH projects in more than 30 countries. Previously he was the Deputy Director of the USAID's FP/RH flagship global project Extending Service Delivery (ESD) establishing a successful technical direction that led to the follow on project Evidence to Action (E2A). Dr. Castaño has over 23 years of experience designing, implementing, and evaluating complex international FP/RH projects in Latin America, the Caribbean, Africa, and Asia. His expertise includes the whole range of reproductive programs: family planning, maternal and childcare, HIV/AIDS, and STIs. He has relevant expertise in operations research, policy change, integrated services, health system strengthening, quality assurance, and scaling up approaches. He has worked for a variety of international organizations including: UNFPA, Planned Parenthood, EngenderHealth, and PVOs/NGOs. In his native country of Colombia he held various clinical, programmatic, and academic positions in the public and private sectors and at universities. As health advisor to the President's Office, he closely participated in the design and implementation of the health sector reform and supported policy development.

Katie Chau is the Senior Youth Advisor for the USAID-funded Evidence to Action Project (E2A) based in Dakar, Senegal. She has a proven track record providing technical leadership on youth sexual and reproductive health and rights at the global and national levels. She has held youth SRHR positions with leading international NGOs, including IPPF, as well as at the national level in Benin, Mali and Senegal. Katie has an MSc. in Public Health from the London School of Hygiene and Tropical Medicine and notable expertise with multi-country AYSRHR program management, the development of national youth SRHR strategies, international and national advocacy, and youth leadership development.

Adama Dicko of Mali holds a Master in Business Law and communications technology. She has been the President of the National Children's Parliament of Mali, National Parliament Secretary General Youth of Mali, Vice President (National Network Peer Educators) and currently serves as the President for the Africa Region of the Youth Action Mouvement YAM/IPPF. She envisions a world without unwanted pregnancy, and believes that no child should come to despair in the world and that men and women are equal. She is passionate about reading, music and social media.

Youssou Diop, Diplômé du CESSI /OMS /Université Cheikh Anta Diop (UCAD) de Dakar, je dispose d'un diplôme de technicien supérieur avec spécialisation en santé publique, enseignement et administration de services de santé et de projet. J'ai une expérience professionnelle de 34 ans. J'ai travaillé comme agent du Ministère de la santé et de l'action sociale du Sénégal pendant 17 ans à divers niveaux (Administration de services de santé; Santé publique; Enseignement et Soins de santé); ensuite j'ai géré pendant 8 ans un projet de santé communautaire de la Croix Rouge Danoise & Sénégalaise en qualité de Coordonnateur de trois régions. Avec IntraHealth, j'ai été pendant 3 ans, conseiller régional SMNI/PF/Palu dans le cadre de la santé de la reproduction et, depuis 6 ans, je fais office de coordonnateur régional du projet de PF.

Colin Gilmartin serves as a Technical Officer with the Health Care Financing Unit at Management Sciences for Health, based in Arlington, VA. In this role, he provides technical assistance in cost modeling of community-based service delivery programs. Prior to joining MSH, Colin lived and worked in Burkina Faso as a U.S. Peace Corps Volunteer.

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Dr. Yolande Hyjazi is Jhpiego's Country Director for Guinea and was recently the Guinea representative for the U.S. Agency for International Development's flagship Maternal and Child Health Integrated Program (MCHIP). She has extensive experience in maternal and reproductive health and family planning and has been actively involved in Guinea's continuing response to the Ebola epidemic.

Anna Macauley (affectionately known as Mama G) is currently Senior Adviser Clinical Services Management for Marie Stopes Sierra Leone (MSSL). Anna joined MSSL in 2000 as an outreach nurse. She was one of the frontline staff involved in introducing one the most needed Family Planning methods- implant insertion and has been at the forefront of increasing access to tubal ligation services, working with a group of Sierra Leonean doctors. Anna has helped in developing clinical protocols, training materials, training service providers and overseeing quality standards in family planning services and has also been closely involved in developing a cadre of community based motivators to deliver short term methods and promote referrals for long term methods. During her distinguished career which spans over two decades, she has worked at all levels – from the grassroots to the highest policy making levels; in direct service delivery, in training and in quality assurance - to scale up family planning services and advocate for policy changes.

Modibo Maiga is the West Africa Regional Director of Futures Group, based in the Ghanaian capital, Accra. He is an expert on family planning and sexual and reproductive health, as well as HIV. Born in Mali, Modibo has dedicated almost 30 years of his life to making a difference in public health, and promoting the effective development of the countries that make up his homeland. From 2002 to 2009, he was Country Director for Mali and Regional Coordinator of the POLICY Project and Health Policy Initiative for Futures Group. Subsequently, Modibo moved into a role as Senior Policy Technical Advisor under USAID's AWARE II, and in 2011 took up his current position as Regional Director for Futures Group West Africa in charge of regional activities under the company's flagship Health Policy Project. Modibo plays a key role in managing AFP's work with partners in Senegal and Burkina Faso.

Joan-Marshall-Missiye is a trained project manager, supervisor, and facilitator, and Senior Project Officer with Management Sciences for Health. Since 2011, she has provided project management and technical support to the USAID flagship project in the DRC, the Integrated Health Project, as well as the Leadership, Management, and Governance Project field support. She is currently providing medium-term technical assistance to the West African Health Organization in preparation for the first ECOWAS Forum on Good Practices in Health. Prior to MSH, Joan lived in Togo as a community health volunteer with the Peace Corps, lived in South Korea as an English teacher, received a Master's degree in Social and Public Policy from Duquesne University in Pittsburgh, researched and wrote about women's roles as peacekeepers in Cote d'Ivoire and Rwanda, and worked as an international development fellow for Catholic Relief Services in the DRC.

Sheila Mensah is Senior Communications, Monitoring and Evaluation Advisor for USAID/West Africa Regional Health Office. Her experience includes designing and conducting research and evaluations, managing projects and people, and leading interdepartmental and inter-organization teams, to achieve objectives through promoting collaboration, effective communication, total quality management, creative problem solving and skills capacity building. As a result, she has made significant contributions to improvements in organizations' portfolios, management processes, business processes, and staffs' performances. Previously, she held position and consultancies in the private sectors of the USA and Ghana, working with firms in the Health Care and Food & Beverage industries. Sheila holds a Bachelor of Science degree in Chemical Engineering from the University of Pennsylvania and a Master of Business Administration from the University of Cincinnati.

Karine Nankam is Jhpiego's Senior Program Coordinator for West Africa. Prior to joining Jhpiego, Karine worked as a Health Program Coordinator for the International Rescue Committee (IRC) in Baltimore. Karine has also served as a Field Operations Manager for the Foundation for International Medical Relief of Children in Uganda and a Community Health Agent for the Peace Corps in Uganda.

Abdoulaye Ousseini coordonne actuellement le projet E2A au Niger à travers un programme intitule « Leadership universitaire pour le changement en santé sexuelle et reproductive des adolescents et jeunes ». Il est spécialisé dans l'analyse des actions publiques de sante en Afrique de l'Ouest. Il a participé en tant que chercheur dans la documentation du processus de la mise en œuvre des politiques de gratuité des soins au Niger, Mali et Burkina Faso. Abdoulaye est socio-anthropologue de la sante titulaire d'un doctorat de l'Ecole des Hautes Etudes en Sciences Sociales de Marseille.

Suzanne Reier has worked for over 30 years in international development situations ranging from community-based health and social service programs to large scale bilateral programs to improve quality of reproductive health services. The majority of her international experience has been in East, North, and West Africa. Suzanne has extensive experience as a manager, trainer and facilitator. She currently works with the IBP Initiative, based at World Health Organization/Geneva in the Reproductive Health Department, to facilitate a coordinated effort of 44 major reproductive health organizations to collectively improve the quality of and access to reproductive health programs. The key elements of this initiative are to foster change and scale up proven, effective practices and programs by harmonizing efforts among partners. She has introduced and trained program managers at regional and country level in Africa, the Middle East, and Southeast Asia to use the IBP Fostering Change Guide and has facilitated scaling-up activities in numerous countries using the ExpandNet model.

Ishmael Kwasi Selassie is an advocate of Sexual and Reproductive Health for young people. He has worked with the Planned Parenthood Association of Ghana since 2002 in various capacities including managing the Association's youth project, Young & Wise Center. Currently, he works as the Youth Focal Person and Learning Center, implementing ASK project, facilitating LDP+ etc. Selassie holds a strong view on the importance of CSE for young people as a critical requirement for their development and informed decision making around their reproductive health. In 2010, Selassie was selected as a member of the UNFPA Global NGO Advisory Panel representing youth led and youth serving NGOs on the Panel. He is currently a member of the National Organizing Committee for the 2016 upcoming African Conference on Sexual Health and Rights (ACSHR 2016) to be held in Ghana.

Brigitte Syan, employée à l'ONG Equilibres & Populations occupe depuis juin 2014, le poste de chargée de plaidoyer et est responsable du projet Advance Family Planning (AFP) au Burkina Faso. Elle a conduit des activités de plaidoyer auprès des autorités nationales et décentralisées (maires) en vue de lever les obstacles à la promotion de la planification familiale et a obtenu des resultats encourageants : autorisation de l'experiementation de la délégation des tâches au Burkina par le ministère de la santé, engagement des maires à prendre la planification familiale dans leurs plans communaux de developpement (PCD), engagement des acteurs du privé à appuyer la promotion de la planification familiale etc. Juriste de formation, avec un master II en gestion de projets, Brigitte a travaillé également à la Coalition au Burkina Faso pour les Droits de l'Enfant (COBUFADE) pendant cinq ans pour la cause des filles travailleuses domestiques vulnérables et laissées pour compte, dont leur santé sexuelle et reproductive avait constitué un axe important du projet. Par ailleurs, elle a conduit et participé à des études sur les droits des enfants, réalisé le suivi des engagements pris par l'Etat Burkina sur la protection des enfants et réalisé des formations au profit des acteurs sur l'utilisation de l'outil AFP SMART.

Nandita Thatte is a Senior Technical Advisor in the office of Population and Reproductive Health at USAID working on the research to practice portfolio. This work includes efforts to identify, implement and scale up high impact practices in family planning and reproductive health in USAID supported programs. In addition to providing global technical support, Nandita supports USAID programs in West Africa, Haiti and Mozambique. Nandita has previously worked in academia and for implementing partners with projects in Senegal, Nepal, Tanzania, and the Philippines. She is currently pursuing a doctorate in public health from the George Washington University.

Annex 3: Case Studies

Fostering Change for Scale-up of Good Practices in the WAHO Region

Fostering Change For Scale-up Of Good Practices In The WAHO Region: The Case of CSE Linking Services in Togo

Introduction

In 2014, IPPF Member Association in Togo, the ''Association Togolese pour le Bien etre Familial'', ATBEF, piloted a holistic and multi-sectorial approach to CSE linked to Youth Friendly Services (YFS) to increase Young People's demand and access to Sexual and Reproductive Health Services in 5 schools and surrounding communities in the Zio Health District, specifically through Tsevie and Davie clinics. Key stakeholders of the initiative included religious and community's leaders, local parents' associations, media, health & education officials from the districts and Youth Clubs.

Background

From 2008 to 2012, the ''Association Togolese pour le Bien Etre Familiale''(ATBEF) had supported the Ministry of Education to implement integration of Comprehensive Sexuality Education in 18 schools with the aims of improving sexual and reproductive health and rights. The project evaluation conducted by an independent consultant showed a considerable improvement in terms of knowledge on Sexual and Reproductive Health and Rights, including contraceptive methods and negotiation of condom use to prevent STI, HIV and unwanted pregnancies among young people. 81.5% of Young People responded that they were able to list negotiation & and use of contraceptives as ways of preventing STI, HIV and unwanted pregnancy against a baseline of 22 % at the beginning of 2008.

The Challenge

Despite the increase in terms of knowledge, there was still a relatively low uptake of services by young people in the area. In 2012, 60% of the total population of Tsevie (GPH de 2010) were reported to be under 25 years of age. However, only 17.2 % of total number of clients of the ''Polyclinique du District Sanitaire de Tsévié'', were young people registered case of STI, 93 of HIV, 21 of unwanted pregnancies and 27 cases of spontaneous abortion.

Adapting the innovation

The changes to be made on the initial ABTEF project (Phase 1&2) were identified by the project evaluation process and report. The evaluation showed, among other results, impact in terms of knowledge increase and a decrease in registered cases of teenage pregnancies in the school involved. The report showed that the first two phases of the project was successful in integrating CSE in school curriculum in the 18 experimental schools, equipped Young people with information and necessary skills to request services they needed. However, the project didn't address other factors that impact the demand and access of Young People to SRH services, such as availability and friendliness of the services, parents and teachers. The project involved parents at national level (which facilitated CSE integration & provision through the school curriculum), but this involvement was limited at national level.

The strengthened innovation ensured the following:

- The Project built capacities of the stakeholders on ASRHR, CSE
- Dialogues among key stakeholders (parents, services providers and teachers)
- Development and delivery of IEC and training materials.
- Capacities of Youth leaders & peer educators, parents, media houses, religious leaders and teachers strengthened through value clarification sessions
- Capacities of Tsevie and Davie Service Providers were strengthened through Youth Friendly service training.
- Radio programs involving religious leaders, parents, media and Youth

- A referral system between schools involved in the project and surrounding communities and existing Youth School Clubs
- SRHR commodities

Planning for demonstration (Phase 3)
A ''linking CSE & YFS project'' committee was set up to lead the phase 3 of the project. This committee was composed of the existing members of the CSE project steering committee at national level and local stakeholders (local media, local parent school associations & federations, local religious leaders, local youth representatives, as well as representatives of the district Health and Education offices).

The project promoted local ownership and used the existing infrastructures and groups in and out of school in the perspective of a future scale up and these include; (school parents committees, school parents' general assembly and periodical meetings, religious leader's federations meetings, Teachers associations, etc.)

Results and Lessons Learned
1. The Tsevie Health District clinic service statistic has shown increase in demand and access of AYP to SRH services in 2014 compared to 2012. However, the pilot has also demonstrated that CSE program doesn't result in all young people demanding SRH services. For some of them, results of a quality CSE linked to YFS program meant decision to abstain or better use of condom & pills available at different service delivery points (not necessary through the district clinic).
2. In 2014, over 60% of counselling provided on adolescents sex and sexuality and reference to the clinic were either by teachers & parents, demonstrating that when parents are informed and capacitated they became great allies of adolescents' sexual and reproductive health and rights.
3. Phase 3 of the pilot is supposed to run until December 2015 with the support of the Choices and Opportunities project funded by the Netherland Government through IPPF.

Opportunities
There is a lot of interest by donors and partners to invest finance and technical support into initiatives that show results of change that results in young people's access and utilization of SRH services. UNFPA, ATBEF and others members of the National CSE Taskforce; the Togo Ministries of Education & Health have recently developed a draft scale up plan for CSE project.

Case Study: Scaling Up Postpartum Family Planning Services, and the Integration of Family Planning with Maternal, Newborn and Child Health Care, in Guinea

A. Background

1. What is postpartum family planning?

Postpartum family planning (PPFP) is "the prevention of unintended pregnancy and closely spaced pregnancies through the first 12 months following childbirth." [2] The World Health Organization (WHO) recommends an interval of 24 months or more before attempting a next pregnancy after a live birth, to reduce the risk of adverse outcomes for mother and child. As a service delivery strategy, PPFP expands access to family planning (FP) through integration of all available and permissible PPFP methods[3] within the existing continuum of maternal, newborn and child health care, resulting in important health benefits by ensuring healthy timing and spacing of pregnancies and the fulfillment of desired family size.

2. Why Guinea?

Like many governments in Francophone West Africa, the Government of Guinea has made international commitments relating to FP, such as the Ouagadougou Partnership[4] and Family Planning 2020 (FP2020),[5] as well as national population and reproductive health policies and strategies that acknowledge the importance of FP for "improving the indicators of socioeconomic development."[6] Guinea has a lower unmet need for FP, at 24%, than most other countries in the West African region,[7] yet the increase in unmet need for birth spacing observed between 2005 and 2012 is statistically significant.[8] Guinea continues to have a high total

Selected Health and Demographic Data for Guinea	
Maternal mortality ratio (deaths/100,000 live births)	724
Neonatal mortality rate (deaths/1,000 live births)	33
Under-5 mortality rate (deaths/1,000 live births)	123
Infant mortality rate (deaths/1,000 live births)	67
Contraceptive prevalence rate	7
Total fertility rate	5.1
Skilled birth attendant coverage	45%
Antenatal care,4+ visits	57%
Sources: World Bank; Ministère Plan 2012; DHSIV.	

[2] World Health Organization. 2013. *Programming strategies for postpartum family planning*. Available at: http://www.who.int/reproductivehealth/publications/family_planning/ppfp_strategies/en.

[3] For the latest medical eligibility criteria for postpartum family planning methods, *see* World Health Organization. 2015. *Medical eligibility criteria for contraceptive use, fifth edition*. Available at: http://www.who.int/reproductivehealth/publications/family_planning/Ex-Summ-MEC-5/en.

[4] *See* http://partenariatouaga.org/pays-accueil/guinee.

[5] *See* http://www.familyplanning2020.org/entities/86.

[6] Republic of Guinea, Ministry of Health and Sanitation. 2013. *Guinea's National Repositioning Family Planning Action Plan for 2014–2018*. Available at: http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2014/11/Guinea-National-Repositioning-Family-Planning-Action-Plan-for-2014-2018.pdf.

[7] MCHIP Guinea End-of-Project Report. 2014.

[8] Soura, Abdramane B. 2014. *Trends in Family Planning and Age at First Marriage among Women in Guinea: Analysis of the 2012 Demographic and Health Survey*. DHS Further Analysis Reports No. 94. Rockville, Maryland, USA: ICF International.

fertility rate of 5.1 among its 2.9 million women of childbearing age, with significant regional disparities: approximately 11% of Guinean women ages 15–49 are pregnant at any given time[9] (resulting in approximately 431,135 births per year[10]), and the modern contraceptive prevalence rate (mCPR) remains low, at just 7.0% in 2012, an increase of only 2.1% from 1999.[11] One of Guinea's national family planning objectives is to increase the mCPR to 22.1% by 2018, corresponding to an additional 520,000 additional users of modern methods of family planning.[12]

Guinea's public health care system includes national and regional hospitals as well as prefectural hospitals in most of its 33 prefectures, but its approximately 450 health centers and several thousands of community health workers provide most maternal, newborn and child health and family planning services.[13,14] Approximately 85% of pregnant women receive antenatal care services (with 57% attending at least four visits), 45% deliver with a skilled birth attendant and 40% deliver in a health facility. Among Guinea's FP2020 commitments are pledges to (1) recruit 2000 health workers in 2014, (2) recruit an additional 51 midwives and 111 government-registered nurses for rural areas and train 300 health technicians to serve as midwives each year until 2017 and (3) continue rolling out long-acting reversible contraceptives and permanent methods in the 15 health districts currently lacking them.[15]

B. Guinea's PPFP Scale-up Process

Three partners, the WHO, the United Nations Population Fund, and Jhpiego, encouraged the Government of Guinea to introduce PPFP as a priority strategy in the national plan to reposition family planning that was first elaborated in 2008. For the implementation, Jhpiego advocated to decision makers, donors and other partners to establish PPFP services, and specifically postpartum intrauterine device (PPIUD) services in 2011, in national hospitals and around the capital city, Conakry, where there were high numbers of deliveries and internship sites for medical and midwifery school students.

Technical assistance was provided from Jhpiego's headquarters to adapt training materials, begin training providers and supply PPIUD insertion kits and other service management tools. Follow-up visits were conducted with the initial cohort of trained providers to ensure the transfer of skills. Within those providers, some were trained and qualified as national trainers to proceed with the extension of PPFP/PPIUD services.

As services expanded, regional trainers were developed to decentralize training and accelerate the scale-up process. These trainers worked in collaboration with the technical staff of Jhpiego/Guinea to cover trainings and supervision.

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[9] MEASURE DHS, ICF International. Guinea: Demographic and Health Survey 2012. Available at: http://dhsprogram.com/pubs/pdf/FR280/FR280.pdf.
[10] *See* UNPD, World Population Projections 2012.
[11] Supra, note 7.
[12] Supra, note 4.
[13] The World Bank, Africa Region. 2006. Guinea: A Country Status Report on Health and Poverty. *Available at:* http://siteresources.worldbank.org/INTAFRREGTOPEDUCATION/Resources/444659-1212165766431/H_CSR_Guinea.pdf
[14] Supra, note 5.
[15] Supra, note 4.

By 2014, 110 of 234 facilities supported by USAID's Maternal and Child Health Integrated Program, which was led by Jhpiego, provided counseling to pregnant women on PPFP, and 34 facilities were offering PPIUDs. The percentage of women counseled on immediate PPFP options who accepted a modern family planning method was just 30% in 2011 and rose to 81% by 2014.

In 2014, a West Africa regional meeting on PPFP/PPIUD was held in Ouagadougou, Burkina Faso and generated additional recommendations for accelerating access to services. Through continued advocacy, these recommendations have been incorporated into Government of Guinea's new national plan for repositioning family planning, which will end in 2018.

Case Study: Scaling up access to modern contraceptive methods in Sierra Leone – A pilot study on the provision of Depot medroxyprogesterone acetate (DMPA) by Community Health Workers (CHWs)

In 2014 the Ministry of Health and Sanitation (MoHS) and Marie Stopes Sierra Leone (MSSL) implemented a study to evaluate the feasibility of CHWs providing DMPA in Sierra Leone. This intervention was chosen in order to demonstrate the possibility of lower level health cadres providing injectables, with the long-term aim of changing policy and practice in order to increase contraceptive choice and access for the hardest-to-reach, most in-need communities.

The challenges in providing family planning services in Sierra Leone are well documented. Access to basic health services in Sierra Leone is restricted for a number of reasons: distance to health facilities; poor and expensive travel infrastructure[i]; and insufficient number of health care workers - Sierra Leone has just 1.7 nursing and midwifery personnel per 10,000 people (data from 2010)[ii].

According to the 2013 Sierra Leone Demographic and Health Survey (DHS) 25% of married women have an unmet need for family planning (FP), 17% want to space births and 8% want to limit births[iii]. The total potential demand (women with met and unmet need) for FP constitutes 42% of women. 49% of currently married women who are not using FP, intend to use it in the future. Injectables, the most popular FP method among all women, are used by 25.9% of sexually active unmarried women, which represents 44% of all FP users in this group.[iv]

In Sierra Leone CHWs are widely used to provide health services directly in the communities. They have been trained to distribute oral contraceptives and condoms and make referrals to Government facilities. A selected few have been trained by the MoHS to provide under-five immunisation. They are mostly rural with effective and efficient monitoring and supervisory mechanisms. The MoHS recognises that community based interventions can reduce costs and barriers to accessing services and considers CHWs as vital to the goal of a maximally participatory health system.[v]

With funding from USAID's "Support for International Family Planning Organizations" (SIFPO) project MSSL approached the MoHS and proposed a joint study on task-sharing DMPA to CHWS. A task sharing advisory committee, including representatives of the MoHS, the Parliamentary Committee on Health, Law Reform Commission, the DHMT and the civil society coalition 'Health for all', was established to support the study and monitor its progress. To enable scale up following this study, as far as possible the intervention was built into existing activities and processes. For example, DMPA provision was added in to CHWs' existing work patterns, existing tools and supervision processes were used where possible.

The study was carried out between July and December 2014. Three training sessions were held by the DHMT and MSSL, with a total of 150 CHWs receiving training. The CHWs included in the intervention were low cadre health workers who work with the DHMT in their community Peripheral Health Units (PHU). Certification of the CHWs was provided by the DHMTs. The certified CHWs then included DMPA counselling and service provision, and counselling of all family planning methods, into the services they offered, alongside distributing pills and condoms, mosquito bed nets and malaria drugs.

The pilot was carried out in the communities in six chiefdoms[16] in the Koinadugu district of Sierra Leone, with each CHW providing services over a three month period. This district was chosen because of its high unmet need, but also because, at that point, it was free from Ebola. In order to ensure community acceptance and support for the pilot, MSSL and the DHMT engaged all the chiefdoms prior to implementation. Community meetings were undertaken during which the DHMT and MSSL presented the CHWS to the communities and all issues relating to the pilot, including the rationale and the ability of the trained CHWs to deliver the services correctly, were discussed.

The supply chain was managed by MSSL. DMPA was stored in MSSL centres in the district and provided to the PHU-in-charges who in turn made the DMPA injections available to the CHWs under their supervision. CHWs were reimbursed 5000 Leone (US$1) per client, the same payment given by the MOHS to CHWs to provide other short term methods and referrals for long acting and permanent methods. PHU In-Charges were reimbursed Le 80,000 (US$16) for travel for each CHW supervised, location monitored and the management of DMPA clinical waste. Monthly data on the project was collated by MSSL and then shared with the DHMT who then shared this data with the MoHS in Freetown. Supervisory monitoring forms were first received by PHU in charges and then sent to MSLL and the DHMT for analysis.

The results of the study show that with specific training and supervision, CHWs can successfully provide DMPA to women in their communities. Acceptability of DMPA provision by CHWs among clients was found to be extremely high. This intervention was successful in reaching first-time users, as well as young women, and women with little education. The proportion of young clients reached by CHWs was greater than the proportion of young injectable users nationally, suggesting CHWs are better than other approaches at reaching the young. The number of DMPA provided by CHWs during the intervention closely matches the increase in DMPA and FP provision in the district in the same period. This may suggest that the intervention successfully reached women who were not accessing a method, rather than taking women from another provider or method.

Due to the Ebola outbreak, the event to evaluate, consolidate and disseminate the lessons learned from the pilot study was postponed until July 2015. Following this event, the task sharing advisory committee will develop and finalise the strategy to scale up and secure resources for the provision of DMPA by CHWS at national level.

[16] Chiefdoms included in the intervention: Kasunko, Sengbeh, Neini, Wara Wara Yagala, Dembelia Sinkunia and Folosaba Dembelia

References

[i] Herschderfer K, Koning K de, M'balu Sam E, Walker P, Jalloh-Vos H, Detmar S. (2012). Barriers and Promising Interventions for Improving Maternal and Newborn Health in Sierra Leone. Amsterdam: Royal Tropical Institute.

[ii] WHO. 2014. The 2014 update, Global Health Workforce Statistics, World Health Organization, Geneva. http://apps.who.int/gho/data/view.main.92100

[iii] Statistics Sierra Leone (SSL) and ICF International. 2014. Sierra Leone Demographic and Health Survey 2013. Freetown, Sierra Leone and Rockville, Maryland, USA: SSL and ICF International.

[iv] Ibid

[v] Ministry of Health and Sanitation. 2010. Basic Package of Essential Health Services for Sierra Leone. Freetown, Sierra Leone: Ministry of Health and Sanitation, Government of Sierra Leone.