E2A TECHNICAL BRIEF

Expansion of Community-Based Family Planning in the Democratic Republic of the Congo: Using a Systematic Approach to Scale-Up

Between 2014 and 2018, with funding from USAID, the Evidence to Action (E2A) Project supported the Ministry of Health (MOH) of the Democratic Republic of the Congo (DRC) to scale up successful pilot interventions that provided integrated community-based family planning (FP) and primary health care services from South Kivu Province to health zones in three additional provinces: Lomami, Lualaba, and Kasai Central.[1]

The original package of interventions, carried out over a four-year testing phase by Pathfinder International's Flexible Family Planning, Reproductive Health and Gender-Based Violence Services for Transition Situations (Flex-FP) Project, were designed to support a largely transient population living in a post-conflict area of South Kivu Province. This population was comprised of refugees, returnees, and internally displaced peoples—many of whom were survivors of rape used as a weapon of war. FP interventions consisted of providing non-clinical contraceptive methods—condoms, Cyclebeads®, oral contraceptive pills, and counseling on lactational amenorrhea—by trained community-based distributors (CBDs). To comply with DRC's existing policy on injections and complement the work of CBDs, the project recruited unemployed nurses living in the targeted communities to provide the injectable contraceptive Depo Provera (DMPA)®. Skilled health providers contracted by the project conducted mobile outreach services delivering primary healthcare services, including maternal and child health (MCH) services; nutrition; treatment of malaria, acute respiratory infections, and diarrhea; voluntary HIV-testing and counseling; and referral services for case management of the consequences of sexual and gender-based violence (SGBV).

The combined interventions yielded an increased uptake of contraceptive methods in project health zones. Through the integrated mobile outreach teams, 7,000 people were reached, 35 of whom accepted DMPA and 632 of whom accepted condoms. Through community-based distributors, over 30,000 households were visited and over 60,000 people were reached with awareness activities, through which CBDs distributed 5,767 DMPA, 121,078 condoms, 7,390 pills, and 4,119 cycle beads.

Based on the success of this pilot project in increasing access to and uptake of FP services, USAID/DRC approached E2A to implement similar integrated community-based family planning (CBFP) and primary healthcare services on a wider scale expanding to 15 of the 25 priority rural health zones in DRC's Lomami, Lualaba, and Kasai Central provinces.

Project Implementation

To promote sustainability and resilience, E2A creates conditions wherein local leaders can take ownership of scale-up processes

E2A undertook this new project with a deliberate effort to use a systematic approach to scale-up, benefiting initially from ExpandNet's tool **Beginning With the End in Mind (BWEIM)**[2] and subsequently from the tool **Nine Steps for Developing a Scaling Up Strategy**.[3]

The BWEIM tool builds on the premise that projects should be organized from the beginning to maximize the potential for large-scale, sustainable impact. The tool proposes 12 recommendations on how this can be accomplished. The following three recommendations were particularly critical for scaling up FP interventions from South Kivu to three additional provinces in the DRC:

- Engage in a participatory process involving key stakeholders;
- Ensure the relevance of the proposed intervention; and
- Tailor the innovation to the socio-cultural and institutional settings.

1 Engage in a participatory process

E2A worked within the existing health system to expand the reach and impact of the interventions to increase sustainability and benefit more people. In applying this recommendation, E2A ensured the project was led by the government. DRC government health authorities, who were critical of what they called typical "project mentality," wherein interventions are dictated by external partners without meaningful engagement with government and community leaders, identified this recommendation as essential.

The National Reproductive Health Program (NRHP) assumed ownership with enthusiasm, even though it meant they had to substantially adjust existing workplans to accommodate this new role and negotiate with other MOH programs to secure their commitment and participation. Several months into the transition to government ownership, NRHP invited a multidisciplinary team from the MOH to form a national Technical Advisory Group (TAG) composed of representatives from NRHP, the Adolescent Health Program, and the Integrated Child Health Program, all of which were interested in using CBDs for community-based health care delivery.

Regular communication between the TAG and the provincial and zonal health authorities ensured integration of project activities into their health operational plans. On a semi-annual basis, the TAG conducted field visits to the provinces and health zones to observe project implementation and provide feedback. The TAG thereby played an instrumental role in ensuring the integrated provision of CBFP and basic childcare interventions.

With the government taking the lead, E2A's role largely shifted to that of facilitator, ensuring communication and exchanging up-to-date information among donor, government, and other implementing partners.

However, where the government lacked capacity to manage activities—such as procurement of equipment and supplies, forecasting and distribution of contraceptives to the health zones, financial disbursement, and management of transportation logistics to facilitate community-based interventions—E2A provided leadership and targeted support.

2 Ensure the relevance of the proposed innovation

The participatory, government-led approach facilitated appropriate adaptations of the original intervention package to the geographic, socio-cultural, and institutional context of the three new provinces.

Prior to scale-up implementation, an MOH-led team partnered with E2A to conduct an in-depth field assessment, which focused on areas for health system enhancement (e.g. aspects of governance/leadership from government, diversification of service delivery modalities, development of human resources, and strengthening community participation). Across the three provinces, the team conducted interviews with high-level health authorities at the provincial and health zonal levels and focus group discussions with key community groups. The assessment findings confirmed the relevance of, and vital need for, an integrated CBFP and primary health care service delivery model in rural health zones.

3 Tailor the innovation to the socio-cultural and institutional settings

The assessment showed that the three provinces were more stable, had lower rates of SGBV, and had a larger and more capable health workforce than South Kivu. One of the necessary adaptations made, therefore, shifted from mobilizing unemployed nurses in South Kivu to using existing nurses and midwives, who had both the capacity and mandate to conduct regular community outreach work and supervise community-based health care delivery through bi-monthly outreaches.

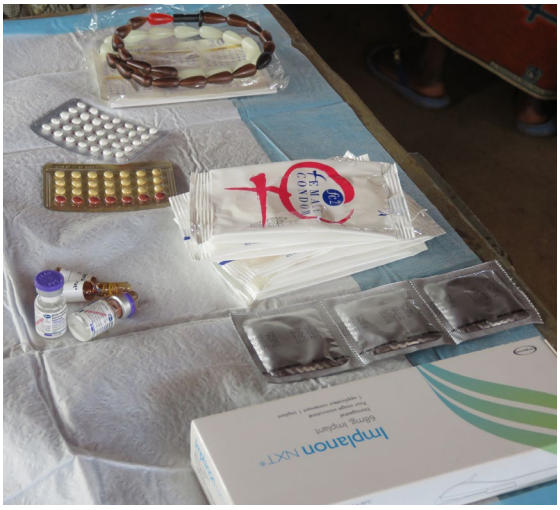
Additionally, through in-depth interviews conducted during the assessment period, an idea emerged: link the provision of free FP with basic treatment services for MCH at a reduced cost during outreaches. Providing integrated services at the community level addressed the challenge of the population's access to health facilities and covered a portion of the cost of outreaches by generating revenue for the health facilities. Therefore, the project determined that, during outreaches, nurses and midwives should not only provide clinical contraceptive services (injectables and implants), but also care for referral cases related to the treatment of malaria, acute respiratory infection, and diarrhea in children.

Another key adaptation was the incorporation of community health huts into the model, which were not present in South Kivu but were functional and present in the intervention areas. Use of these existing health huts reduced the necessity of long-distance travel across difficult terrain for the population and health huts were therefore considered as implementation units and depots for FP commodities.

As rates of SGBV were lower in the three new provinces than in South Kivu, the project team shifted its model to address other gender and youth components. These elements included ensuring equitable representation of women with community health committees, recruiting equal numbers of women as CBDs and women and youth as community champions, and providing counseling for couples during household visits to encourage joint decision making. These and other major changes made in the interventions are summarized in Table 1 on the following page.

"This population is widely dispersed. Accessing health facilities is costly and difficult. It takes a long time to travel across this tough terrain. The assessment, led by the Ministry of Health, showed that adapting these services to these new, rural contexts is critical."

—Aben Ngay, Senior Country Director, Pathfinder DRC



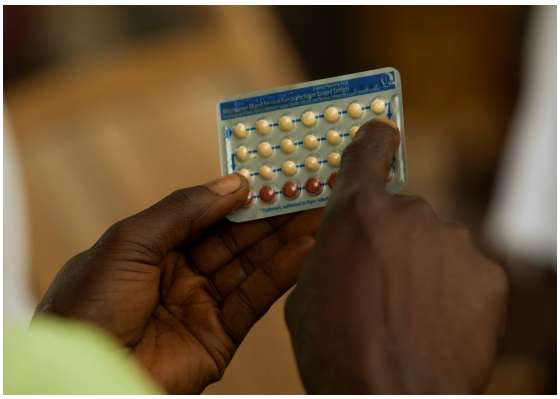


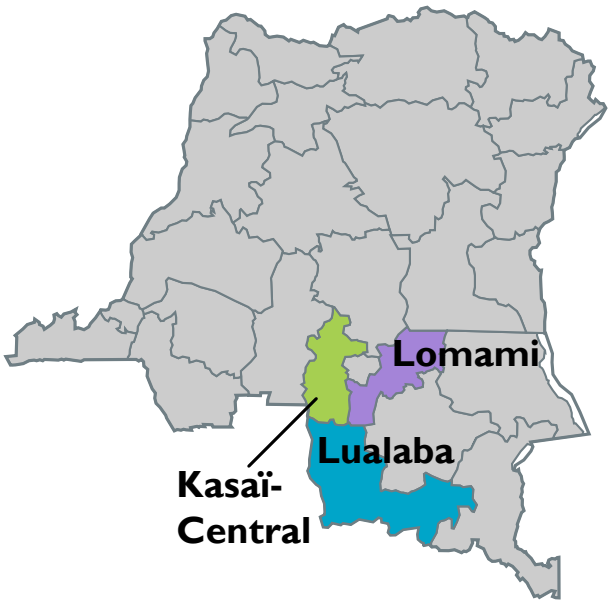
TABLE 1: ADAPTATIONS FROM THE SOUTH KIVU MODEL TO KASAI CENTRAL, LOMAMI, AND LUALABA.

SOUTH KIVU (ORIGINAL MODEL)	LOMAMI, LUALABA, AND KASAI CENTRAL (ADAPTED MODEL)
Mobile primary health care (PHC) services	• Link the provision of free FP with basic treatment services for MCH during outreaches • Community-based provision of ORS/zinc
Community-based distribution of non-clinical methods and Depo Provera® injections	• Addition of community-based provision of implants and DMPA SC/Sayana Press® • Addition of community-based adolescent and youth sexual and reproductive health (RH) component
Prevention and case management of sexual and gender-based violence (SGBV), especially rape	• Replaced SGBV interventions with a focus on gender issues through equitable representation of women and male involvement in RH/FP
Selection process for CBDs done by project	• Selection of CBDs done jointly with the communities (as per national guidelines)
A combination of CBDs and unemployed nurses (all unpaid) provide FP services	• Existing facility-based nurses and midwives (paid) focus on delivering implants and injectables through outreaches • Addition of community-based men, women, and youth champions
Project monitoring using crisis updates (community-based data)	• Program monitoring using service data distinguishing between facilities and communities • Government-led periodic reviews at all levels of the health system
Evaluation process based on project monitoring & evaluation indicators	• Government-led definition of results and process indicators

Driving Project Implementation

Implementation in **51 health areas** of **15 health zones** in the new provinces began in May 2015. E2A, in consultation with the communities, chose CBDs and community champions to participate in the CBFP project. Trainers from the provincial health departments, reproductive health programs, and zonal health teams trained CBDs on: interpersonal communication, counseling and provision of non-clinical FP methods, oral rehydration salts/zinc for prevention of dehydration due to diarrhea in children, and data collection and reporting. Community leaders and champions were also trained in interpersonal communication, counseling, and referrals for FP methods. National government trainers trained provincial trainers who then conducted step-down trainings to facility-based nurses and midwives in FP counseling and provision of FP methods, prevention and management of dehydration, and supervision of CBDs. During these sessions, all providers (facility and community) were also trained in youth-friendly approaches, gender norms, and conducting community outreaches. Providers subsequently conducted community-based outreach, distribution, and demand generation in their communities.

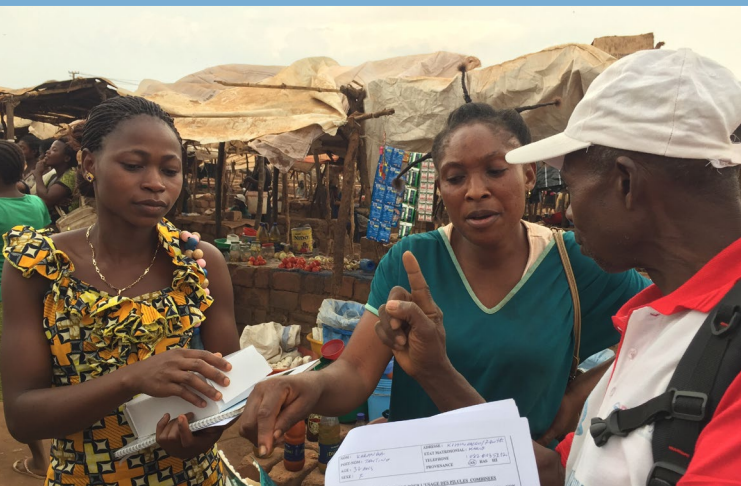
Delivering Results in the Three New Provinces



The adapted interventions and processes in the three new provinces (covering a total of 51 health areas within 15 health zones) achieved significant positive outcomes as follows:

- Throughout the project, a total of **231,566 new adopters** of modern contraceptive methods and a total of **149,826 couple-years** of protection were recorded.
- Out of all the methods provided, community members most often opted for Cyclebeads®, which they said were easy to use, considered a "natural" method without side effects, and aligned with religious and cultural preferences. Men demonstrated increased interest in this method and some took it upon themselves to wear the beads as a necklace and to use as a tool to further engage in discussion with their wives about their reproductive lives.
- **14,316 implants** were distributed through outreaches, making significant contributions to couple-years of protection. This was made possible through the use of facility-based nurses and midwives during outreach events, which were organized every other week in all the targeted health areas.
- The evidence required by the central MOH for the feasibility, acceptability, and safe delivery of DMPA-SC/Sayana Press ® by trained CBDs was generated through a successful testing phase carried out in the Lualaba province project sites in collaboration with Kinshasa School of Public Health and Tulane University. Subsequently, more than half of the CBDs who worked with E2A in the three provinces received special training to enable them to administer this injectable contraceptive in the targeted health areas.

Looking Ahead to Further Scale-Up



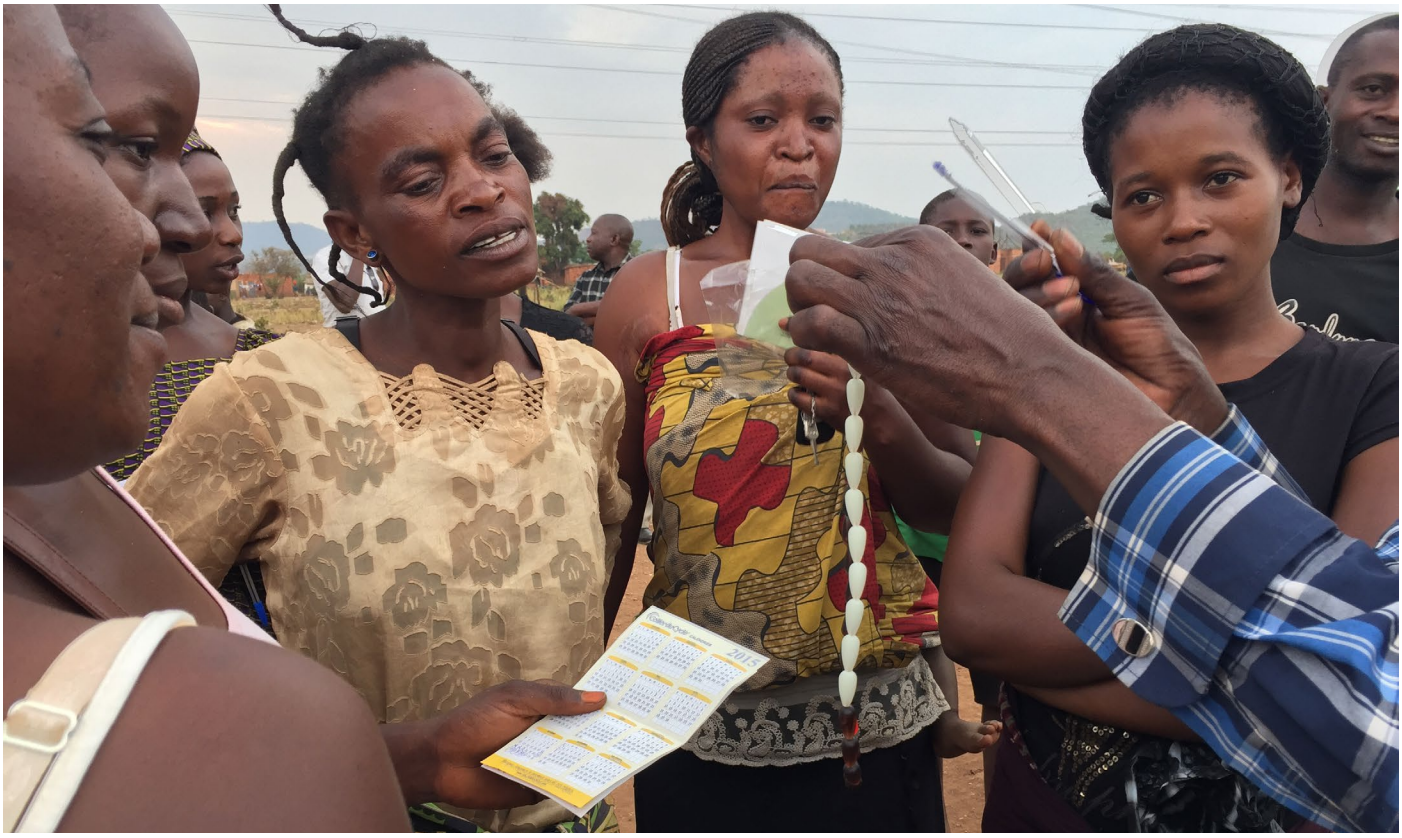
At the end of the fourth and final year of the project, E2A again responded to the government health authorities' request to move away from the typical "project mentality" of development efforts. Prior to the project close-out, E2A supported NRHP and the TAG to address the following questions:

- What can a project in its ending phase do to pave the way toward future scale-up of these interventions for additional health zones in the three provinces as well as other provinces?
- What guidance can be given to help sustain the gains in the health zones and health areas where the approach was successfully tested?

In keeping with the systematic approach to scale-up described in Beginning With the End in Mind, E2A, along with government partners, followed specific steps to document the successful adaptations of the interventions and their implementation and therefore plan for sustainability. A set of evidence-based practices (proven, promising, and emerging) that arose from the "provision of integrated services in rural areas through community-based actors," by which the E2A approach is now referred, has been compiled to facilitate its dissemination and possible large-scale adoption. These practices include the training of non-medical CBDs to administer DMPA-SC Sayana Press® injections in the community and the support of existing facility-based nurses and midwives to organize integrated outreaches to deliver clinical contraceptive methods, especially implants, to clients who otherwise would have difficulties accessing them at the health center level. Additionally, even though its involvement in the 15 health zones across the three provinces through the CBFP program was ending, E2A facilitated a government-led two-day scaling-up strategy development exercise based on the ExpandNet/WHO nine-step approach.[4] Key results from this exercise are summarized in Table 2.

TABLE 2: RECOMMENDED ACTIONS FOR SCALING UP THE *PROVISION OF INTEGRATED SERVICES IN RURAL AREAS THROUGH COMMUNITY-BASED ACTORS* APPROACH

9 STEPS FOR DEVELOPING A SCALING-UP STRATEGY	ACTION	PRIORITY
1. Planning actions to increase the scalability of the innovation	The intervention may not need to be further simplified given it was successfully adapted from the "Flex FP Project" and its feasibility was confirmed throughout implementation in the three new provinces.	Moderate
	There is need to focus future efforts on helping providers and community-based actors maintain their skills and commitment to the provision of this integrated services approach (e.g. address the issues of CBDs' high attrition and dwindling motivation).	High
2. Increase the capacity of the user organization to implement scaling up	Retain NPRH as the lead partner and include key actors from other programs—such as the cholera elimination program, the Communications Directorate, and the National Health Information System—to strengthen their advisory/oversight role for managing the scaling-up process.	High
	Agree on terms of reference and a schedule for regular meetings.	High
3. Assessing the environment and planning actions to increase the potential for scaling-up success	Keep abreast of ongoing reforms and reorganization within MOH.	High
	Work with the logistics system to monitor availability of commodities that are essential for the interventions, including contraceptives and ORS/zinc.	High
4. Increasing the capacity of the resource team to support scaling up	Invite participants from the scale-up workshop to join the resource team. Create provincial resource teams including the Provincial Health Divisions, provincial NPRH, the National Health Program for Adolescents, Zonal Chief Medical Officers, and other key zonal health team members.	High
	Include local level leadership from the health zones including chief nurses and CBDs.	Moderate
5. Making strategic choices to support vertical scaling up (institutionalization)	Engage with the ongoing health sector reform process to gain donor and government commitment for the innovation: provision of integrated services in rural areas through community-based actors.	High
	Integrate distribution of DMPA-SC by non-medical actors in the ongoing revision of national norms and guidelines.	High
	Integrate oversight of the innovation into supervisory schedules, codify data collection and reporting, and include in NHIS.	Moderate
	Explore the possibility of implementing a survey in targeted provinces to ascertain changes in contraceptive prevalence rates (CPR).	Moderate
	Create integrated training tools and technical briefs for ease of use by implementers.	High
	Advocate to include the intervention in the upcoming PROSANI+ project. Explore mechanisms to mobilize resources for CBDs' work compensation.	High
6. Making strategic choices to support horizontal scaling up (expansion/replication)	Support provincial health divisions to progressively scale up the intervention to other health zones in the targeted provinces.	High
	Support provincial resource teams to choose additional sites based on considerations of accessibility, economic viability, and other regional differences.	High
	All expansion sites should use the essential package (i.e. FP and basic child health care, orientation on gender issues, and male involvement) from the three provinces. However, implementation can be flexible according to the context as in Kasai Central, where, due to unrest, the package was adapted to conduct more home visits.	High
	Disseminate the results from the CBFP project services to other provinces to demonstrate feasibility of this innovative approach and generate political commitment.	High
7. Determining the role of diversification	After implementation of the basic package, assess how to best integrate adolescent RH components, as was done in the three provinces. Another addition to be considered: development of FP champions for enhancing community awareness.	Moderate
	Continue discussing diversifying the interventions with integrated strategies related to diagnosis and basic treatment of childhood illnesses (e.g. the vaccination program).	Moderate
8. Planning actions to support spontaneous scaling up	Pay attention to health areas outside of project sites in targeted provinces to assess whether and how the innovation is spreading from one service setting to another.	Moderate
9. Finalizing the scaling-up strategy and identifying next steps	Ongoing	Low



The scale-up strategy can be used by future implementers as a "roadmap" to sustain the interventions in the three provinces and expand this initiative to additional health areas in the country. The project close-out was used as an opportunity to call for a continuity of E2A's approach to community-based FP services in the DRC by other funding and implementing partners as well as the MOH, which was encapsulated in the following message: "Aujourd'hui nous tournons une page, mais la lecture continue!", which means "Today we are turning a page, but the reading continues!"

Following project close-out and the elaboration of this scale-up strategy, E2A was awarded another year and additional funding to continue this approach in selected health zones and expand to several new health zones in the Kasai Central, Lomami, and Kasai Oriental provinces. In addition to horizontal scale-up, this phase of the project will continue to institutionalize key components of the intervention that were newly introduced in the provision of FP community-based services, such as the provision of long-acting FP methods by nurses in community outreaches and provision of DMPA-SC by trained CBDs through the revision of national norms and guidelines. This additional investment reflects the positive response the project engendered from both the DRC government and USAID. This "CBFP+" continuation will serve as a mechanism to sustain gains made under the CBFP program and further achieve scale and sustainability of CBFP.

REFERENCES

1. For a detailed description of this initiative see Mai, Murtala et al., 2018. "The role of government ownership and adaptation in scaling up community-based family planning in the Democratic Republic of the Congo" (submitted for publication)
2. ExpandNet, WHO. Beginning with the End in Mind: Planning Pilot Projects and Other Programmatic Research for Successful Scaling Up. Geneva: WHO (World Health Organization); 2011. http://www.who.int/reproductivehealth/publications/strategic_approach/9789241502320/en/.
3. ExpandNet, WHO. Nine Steps for Developing a Scaling up Strategy. Geneva: WHO (World Health Organization); 2010.
4. *Ibid*

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