Uplifting rural communities: Building a scalable model for community-based family planning in Democratic Republic of the Congo

Program Brief
March 2017

DRC: Population and Health

Population: 73 million[2]

Projected population growth by 2050: 165%[2]

Total Fertility Rate, Rural: 7[3]

Contraceptive Prevalence, Rural: 4-5%[3]

Unmet need for family planning, rural: 27%[3]

Maternal mortality rate: 730 deaths/100,000 live births[2]

Under-5 mortality rate: 104 deaths/1,000 live births[3]

About E2A

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

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

Introduction

The Government of Democratic Republic of Congo (DRC) has been making a concerted national effort to strengthen access to quality family planning services—particularly for rural, hard-to-reach communities who comprise most of DRC's population. The USAID-funded Evidence to Action (E2A) Project has been supporting these efforts by working closely with the Ministry of Health to develop a community-based model that applies family planning best practices to complement clinical services and has the potential to be scaled up nationally.

E2A's USAID/DRC mission-supported community-based family planning program combines interventions that:

- generate demand for services;
- ensure availability and accessibility of services including a range of contraceptive choices;
- strengthen provider capacities for delivering family planning services;
- empower communities to play an active role in improving health and development; and
- institute a gender lens across activities to address gender norms that inhibit the delivery and uptake of family planning services.

By working closely with national, provincial, and local stakeholders—including frontline health workers and local health officials—from program initiation, and applying ExpandNet's guidance on systematic scale-up, *Beginning with the end in mind*, E2A has helped to embed family planning services into zonal and provincial health systems, thereby strengthening the chance of sustainability and scale to reach more people in DRC.

Background

DRC, one of the largest countries in Africa, spans more than 1 million square miles. Poor roads and infrastructure coupled with a recent history mired by years of conflict and unrest present great challenges to improving

health and development, especially in the vast rural areas of the country.

More than 65%[1] of DRC's 73 million[2] people live in rural areas, where family planning services have largely been out of reach. The family planning services that have been offered in the country have mainly been provided at health centers—often many kilometers away from where communities actually live.

Coupled with a challenging geography and political history, deeply entrenched gender norms inhibit women's uptake of family planning services in DRC. Women are not the main decision makers about the health of their families and many do not have the agency to control their own fertility desires and exercise their reproductive choices. As a post-conflict society, gender-based violence is pervasive.

Without women's ready access to family planning information and services, the average family size in DRC is now the largest in the world. In their lifetimes, women in rural DRC have more than 7 children.[3] In much of the country, large families live in extreme poverty without access to clean drinking water, electricity, or a functional toilet.[3] Large families correlate with the extremely limited use of contraception among Congolese women: Of married women 15-49 years old, just 8 percent of women nationally and just 4 to 5 percent of women in rural areas use modern contraceptives.[3] The extremely high fertility rate in DRC has led the United Nations Population Division to project that DRC's population will grow by 165 percent—to 194 million people—by 2050, which would make DRC one of the 10 most populous countries in the world.[4]

Since 2009, the Government of DRC has been repositioning family planning to be a national priority, and in last three years, has taken several steps to ensure that family planning services are integrated into the basic package of primary healthcare services offered by the public health system. In 2013, the Ministry of Health's Department of Reproductive Health held the first National Conference to Reposition Family Planning, created a National Family Planning Working Group, and one year later, enacted the Family Planning National Multisectoral Strategic Plan (2014-2020). Also in 2014, the government added a budget line item for family planning to the national health budget. As a result, international donors and partners have increased their support to the public health system to initiate and improve family planning services as part of DRC's integrated package of primary healthcare services.

In DRC, public health services are delivered through a decentralized, three-tiered system, with 26 provinces divided into districts, which are then further divided into 515 health zones, which contain 15 to 16 health areas each. As of May 2014, at the initiation of E2A's community-based family planning program in DRC, only 350 out of 516 health zones were offering any family planning services. Of these, some health zones only offered limited contraceptive choices, mainly nonclinical short-acting contraceptive methods. Large swaths of the population were still without any access to contraceptive services, or could only access a limited range of methods that did not include clinical methods like injectable contraceptives and long-acting reversible contraception.[5]

Figure 1. Intervention Provinces

E2A's Community-Based Family Planning Program

To address these gaps, E2A has been working in partnership with the Ministry of Health to develop, implement, and monitor an integrated, community-based model for family planning service delivery that reaches rural communities with critical family planning and child health services. This integrated package of services includes:

- Community-based distributors (CBDs) who conduct household visits and participate in outreach events in communities to provide: family planning information and counseling; a range of nonclinical contraceptive methods including progestin-only pills, combined oral contraceptive pills, male and female condoms, Cycle Beads for Standard Days Method, and guidance to postpartum women on practicing Lactational Amenorrhea Method (LAM) and exclusive breastfeeding.
- Nurses who work at health centers, health posts, and at outreach events in communities to provide: family planning counseling and provision of the aforementioned nonclinical contraceptives as well as long-acting contraceptive implants and injectable contraceptives.

Box 1. Changes to program design based on collaborative approach

Based on the collaborative design process, changes to the initial proposed project approach included:

- **reducing project coverage from 25 to 15 health zones**
- **engaging existing nurses and health volunteers instead of retired nurses, as originally proposed**
- **incorporating buffer stocks for health zones and commodity forecasting training for providers and health officials**
- **including approaches to motivate community-based distributors and address sociocultural barriers and gender power dynamics related to family planning**

- CBDs and nurses who conduct interventions necessary for the Integrated Management of Childhood Illnesses including provision of oral rehydration salts, zinc and water purification tablets, and encourage postpartum women to continue breastfeeding.

This community-based model reaches underserved, rural populations where they have easiest access: in their homes, at public spaces where they frequent and gather, and at their nearest health centers and health posts. This approach revitalizes a network of DRC's community health volunteers to serve as CBDs of the integrated services. These CBDs are directly supported by facility-based nurses and local health officials in their communities to generate demand for and deliver these services at the same time that E2A works with the Ministry of Health to strengthen health systems.

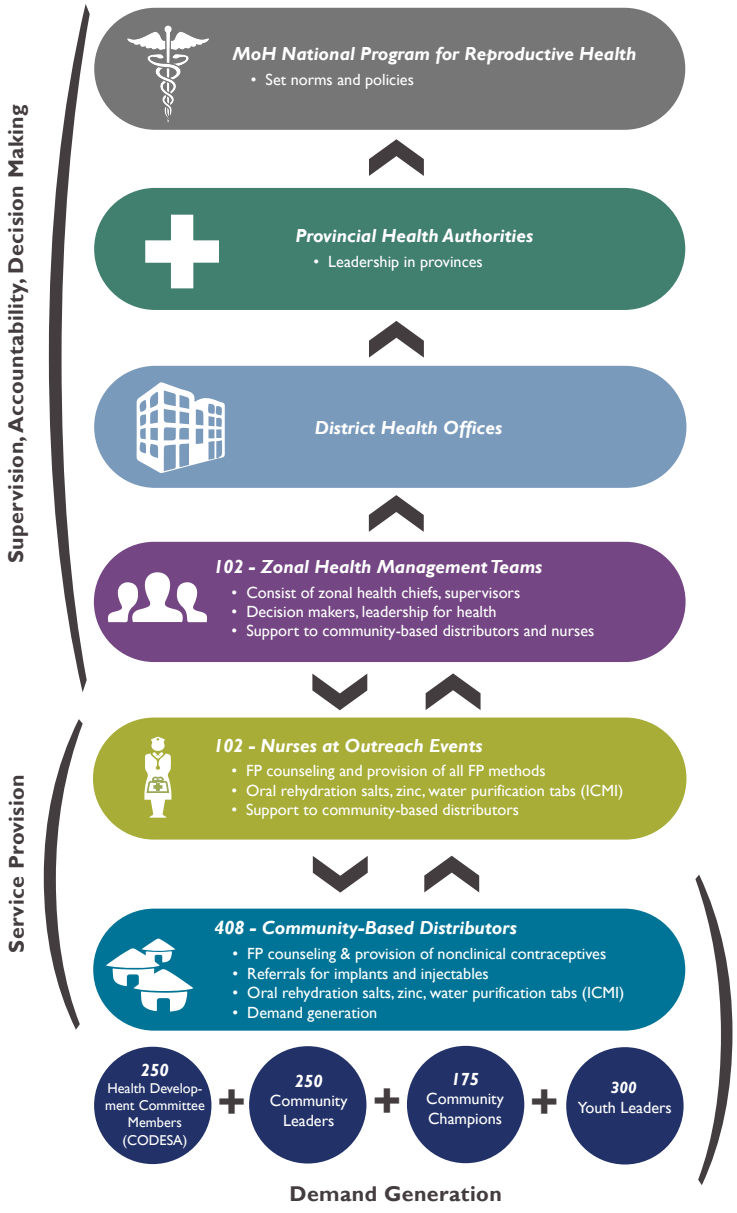
The program operates in 51 health areas of 15 health zones in three largely rural provinces—Lualaba, Kasai Central, and Lomami. The program reaches a population of approximately 786,000, which includes approximately 165,000 women of reproductive age.

Program Design

Beginning with the end in mind

E2A designed the community-based program as a scalable initiative—that is, to expand the potential reach, longevity, and impact of the interventions to reach more people and to make the interventions sustainable in the long-term. E2A designed the program using recommendations from its core partner ExpandNet's guidance tool, *Beginning with the end in mind*.[6] This included holding a series of stakeholder consultations with national

Figure 2. Design of Community-Based Family Planning Program



policymakers, technical experts, local health authorities, and frontline health workers and implementers from June 2014-May 2015. The consultations provided a platform for refining the program work plan and aligning it with national strategies and provincial health plans, and identifying existing synergies and resources within the public health system that could be leveraged to strengthen community-based efforts.

To further refine program design and ensure the relevance of proposed interventions to local and provincial health priorities and plans, national policymakers from the Ministry of Health, provincial health authorities, and health zone officials designed and implemented a collaborative assessment that they conducted in the three target provinces. The assessment documented local health needs and priorities, validated gaps and weaknesses, sensitized future implementers, determined the relevance of proposed interventions, and identified the intervention health zones within the three provinces that would be covered. The health zones and health areas selected for interventions were based on criteria, including:

- Number and capacity of community health volunteers, their stature within the communities they serve, challenges they face, and support they receive
- Number and capacity of sites for Integrated Management of Childhood Illnesses
- Existence and capacity of other community-based structures such as community-based and faith-based organizations
- Existence and capacity of health development committees, referred to in DRC as CODESAs
- Support from other implementing partners to both facility-based and community-based health services
- Systems for procurement of supplies and commodities, referrals , data collection and management, and supervision of community-based services

E2A purposefully selected zones where the Integrated Health Project (IHP) was already operating to complement the work IHP had been doing to strengthen the health system, and in particular, family planning services offered at health centers.

The enabling environment for implementation aligned and institutionalized family planning as part of national, provincial, and zonal public health system structures. For the first time, the Ministry of Health is including data from community-based family planning and maternal, newborn and child health services in the national Health Management Information System. Thirteen out of the fifteen health zones reached by the program integrated family planning into their annual work plans, and all health zones incorporated systems for supervision and oversight of family planning services. Monthly review meetings now serve as a platform for provincial and zonal health officials and services providers to collaborate. These changes strengthened the health system and provided a solid foundation for implementation of the community-based family planning program.

Box 2. Outreach events

At outreach events, organized bimonthly in each health area in communal spaces like markets and parks, community-based distributors and nurses from nearby health centers work together to provide family planning services. At each event, eight community-based distributors provide information on family planning including all the contraceptive methods available, lead public conversations about family planning, and refer people for family planning counseling and methods in a temporary clinic set up for the day. Two nurses in the temporary clinic provide family planning counseling and methods including injectable contraceptives and long-acting reversible contraceptive implants. Health management teams from zonal health offices and E2A staff provide supportive supervision. Nurses also provide implant removal services at these events.

At $60 per outreach, the events are a cost-effective approach to providing the full range of family planning methods to rural populations, particularly in places where human resource capacity is constrained and there is no national task-sharing policy. For example, at one outreach at a central market in Lualaba Province, 355 people became new family planning acceptors. Nurses administered 11 implants and 2 injectables, and community-based distributors distributed 107 Cyclebeads, 28 female condoms, 114 male condoms, 34 progestin-only pill packs, and 59 oral contraceptive pill packs.

Implementation Experience

Aligned with DRC's three-tiered health system , E2A's implementation experience has built the capacity of provincial and zonal health systems to initiate and improve the quality of integrated community-based family planning and maternal, newborn, and child health services in 51 health areas of Lualaba, Kasai Central, and Lomami provinces.

At the heart of this experience is a cadre of 408 CBDs who are directly supported by nurses and local health officials in the

communities they serve. Most CBDs had been serving as community health volunteers before being trained by E2A to provide family planning services. They possess a unique set of characteristics which make them trusted and particularly effective providers.

They are:

- Elected and supported by local authorities
- Residents in their villages for more than six months
- Known, accepted in village
- Willing to volunteer
- Available two to three hours daily
- Able to speak the local language
- Literate

E2A specifically built the capacity of CBDs to:

- Provide quality family planning information, counseling, and short-acting methods.
- Collect and report data at community level.
- Address gender issues that have historically inhibited the uptake of family planning methods when counseling community members.

CBDs volunteer two to three hours each day, making household visits where they counsel women, men, and couples on family planning and provide nonclinical contraceptive methods. Because it is inappropriate in some communities for a man to enter a household when a woman is alone or to speak privately with a woman other than his wife, the female CBDs have an important role to play. At the start of the program, the representation of women CBDs was low, so E2A worked with the Ministry of Health to recruit female CBDs to provide services to other women in their communities; 55 percent of CBDs are now women.

Box 3. Champion Communities

In five health areas, E2A is piloting a community mobilization approach referred to as "Champion Communities." Diverse stakeholders comprise Champion Communities, such as community leaders, health officials, local political leaders, and youth leaders. The Champion Communities approach is adapted from the DRC Integrated HIV/AIDS Project (ProVIC). The approach entails development of a steering committee that creates action plans around certain pressing issues, such as access to family planning. The steering committee offers incentives to the community, including reparations to the health center, for outreach efforts conducted under the Champion Communities platform.

CBDs conduct demand-generation activities in the communities, including group sensitizations on topics such as family planning, hygiene, safe delivery, and diarrheal management from waterborne illnesses. They refer people to health posts and health centers, where they can receive services from a trained nurse, including clinical methods such as long-acting reversible contraceptive implants and injectable contraceptives. Nurses from local health centers directly support and motivate the CBDs at outreach events (Box 2), health posts, and in their communities. Topics include family planning, hygiene, safe delivery, diarrheal management from waterborne illnesses.

Demand generation

CBDs are just one group of several that raise awareness about family planning services in their communities, address some of the gender and social barriers to family planning use, and refer people in their communities for family planning services. E2A tapped into existing networks of community leaders and cultivated new advocates, including: 250 health development committee (CODESA) members; 250 community leaders; 175 people who make up "Champion Communities (Box 3); and 300 youth leaders.

- CODESA members are charged with setting health priorities in their communities and developing strategies to address salient health issues. They help to address communities' health needs by advising on the financing for health centers. They are volunteers elected by their communities.
- Community leaders hold group sensitization sessions in their communities, and religious leaders, in particular, engage men in discussions about family planning. Community leaders also participate in radio segments, where, three times each week, they speak out about important topics to the communities, including family planning.
- Youth leaders reach out to other young people in their communities to encourage the acceptance and use of contraceptives among their peers. The youth leaders are volunteers who E2A engaged to reach out to their peers to discuss young people's sexual and reproductive health needs and how they can be met.

Clinical services

Across all activities in DRC, E2A looks for ways to catalyze new and existing partnerships and to integrate activities into existing efforts. E2A has engaged 102 nurses

who work at health centers and health posts to provide family planning services. While the nurses working at the health centers had already been trained by IHP to offer family planning services including provision of long-acting contraceptive implants, E2A trained nurses at health posts to administer implants as well, bringing access to long-acting methods closer to some communities. Health posts were built in some communities to make up for the long distance from the community to the health center.

The nurses provide family planning services to clients, many whom are referred by CBDs. They also support the CBDs at outreach events, health posts, and in their communities. Women can therefore obtain the full range of contraceptive methods, including implants and injectables, at health centers, health posts, and outreach events. The nurses receive refresher trainings from E2A on family planning compliance and participate in gender trainings like all other implementers engaged by the program.

Health systems strengthening

Health management teams: Zonal health officials, who were directly involved in planning the interventions implemented by the program in their health zones, lead health management teams who oversee service delivery. The health management teams consist of the zonal health chief, supervisors who oversee the family planning and child health services offered by CBDs and nurses, and an animateur *communitaire* who oversees the CBDs and all community awareness-raising activities. They visit every health area once each month to provide supportive supervision to all CBDs and nurses working on program interventions. Among the three provinces, there are 50 supervisors who oversee activities in the 51 health areas. Their supervision focuses on management and collection of data, stock management, and provision of safe and compliant family planning services, including family planning counseling that focuses on the full range of contraceptive methods available and honors voluntary informed choice. The health management teams report to the provincial health authorities who then report directly to the Ministry of Health's National Program for Reproductive Health.

Contraceptive stock management and forecasting: E2A has worked with other implementing partners and government stakeholders to strengthen existing stock-management and procurement systems. To deliver contraceptives to the 15 implementation health zones, contraceptives are shipped with other essential medical supplies from Kinshasa, DRC's capital city, by air to the airport nearest to each of the three provinces where E2A operates. From there, contraceptives are driven to three provincial health offices in Lualaba, Kasai Central, and Lomami. E2A has trained key staff at provincial health offices, who work with CDR—a public-private partnership that manages stocks and commodities—to manage and forecast contraceptive stocks. Zonal health chiefs are responsible for organizing the shipment of contraceptives from provincial health offices to their zones, where they are then sent to health centers and health posts. CBDs can restock at either health centers or health posts, depending on which is more convenient. E2A has also trained nurses at health centers and posts in stock management and forecasting. The stock-management system was initiated by IHP.

Gender integration

Gender norms in the DRC can negatively affect if and how women and men exercise their reproductive choices, including their use of family planning services. E2A has employed a strategy that intentionally integrates gender across recruitment, demand generation, and service delivery activities. This began with orienting program staff and provincial government stakeholders on gender norms and their influence on family planning-related attitudes, behaviors, and practices, as well as on planned activities to build gender responses within program interventions. A team from each zone (zonal health chief, supervisor, and CBD) then participated in a training of trainers, where they identified gender norms and roles, reflected on how these create barriers to accessing family planning services in their communities, and discussed how to support communities in building their understanding and response to problems related to gender. These trainers then continued to roll out gender capacity building through all community and service delivery channels working with the community-based family planning program.

> **"Male community-based distributors have decided to change their own behavior. There are men who cook on the weekends and cultivate together with their wives."**
>
> *- Jimmy Ngoie, Chief of Lualaba Health Zone*

Gender issues are integrated into family planning sensitization efforts. Community agents lead activities and discussions that explore if and how different gender norms limit women and men's access to family planning information and services, their communication about health issues, and their roles in making decisions about their own health and the well-being of their families Community agents make a special effort to engage men, not just to encourage their

support of family planning use, but also to reflect more broadly on how gender norms affect their relationships, choices, and actions in their families and homes; this includes, for example, encouraging husbands' support for their postpartum wives to exclusively breastfeed for six months postpartum. In some communities, male CBDs have become role models, demonstrating how rethinking gender dynamics—from taking on household chores to communicating more openly with their partners on a range of household issues—can benefit not just the individuals, but entire families and communities. CBDs apply a gender lens across all of their work as well, particularly in their counseling of women and couples.

Health development committees (CODESAs) develop strategies to tackle imminent health issues. CODESA members, who are elected by their communities, prioritize the health issues that are addressed by their communities, in part, by advising the budgets for health centers and health posts. E2A, through gender trainings, therefore set a specific objective for the program of seeing more women elected to CODESAs. While at program start, 17 percent of the CODESA members were women, within 18 months, communities had elected women to hold 42 percent of CODESA seats among the 51 health areas covered by the program. Women's representation on CODESAs is higher in Lualaba Province (49 percent), where gender norms are less entrenched, than in Kasai Central and Lomami (40 percent).

Perceptions of the Community-Based Family Planning Program in Lualaba Province

"People don't get the information they need. There is a lot of ignorance. Women are exposed to different hardships because of their vulnerable status. Women need to be allowed contraceptives. Because I have been elected in my community and most people know what I do, they trust me."

- Paulin Ngwej Mushid, Community-based distributor

"I became a health volunteer to contribute to my local community. After being trained by E2A, I organize monthly household visits on different topics. On the weekends, I discuss family planning with couples, but during the week, just the women. People have been asking 'where are you coming from?' 'What were you waiting for?'"

- Huguette Mumba, Community-based distributor

"Women are more marginalized than men in terms of the family planning information they receive. I learned how to ensure there is equity between men and women and how to bring family planning messages to marginalized populations. We work to integrate men into family planning decision making."

- Jonathan Ishama Binene, Nurse

"Because of the number of children we have and our household income, we cannot support the children. I decided with my husband to take an implant. It was a shared decision."

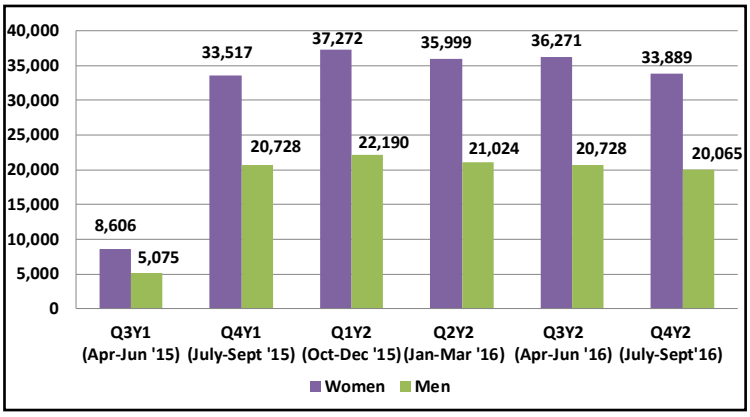
- Veronique Kabadi, mother of 6, new family planning acceptor

"We make sure women can be involved in activities for women's empowerment. We discuss different topics related to health and make strategies related to problems in our communities. We go to where men are when they return from work and discuss family planning with them and stay in touch with other men in our communities."

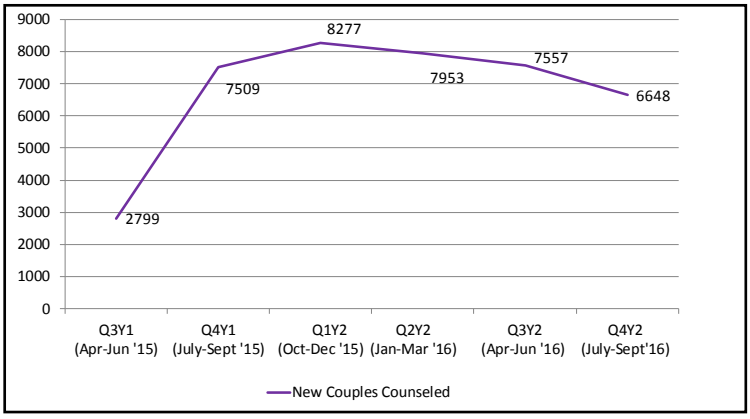
- Upite Koniki, Female CODESA President, Manika

Results

Graph 1: Individuals who participated in family planning counseling with CBDs



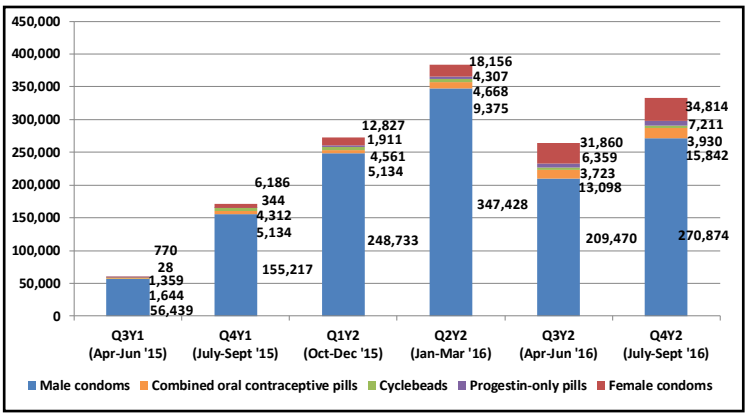
Graph 2: Couples who participated in family planning counseling with CBDs



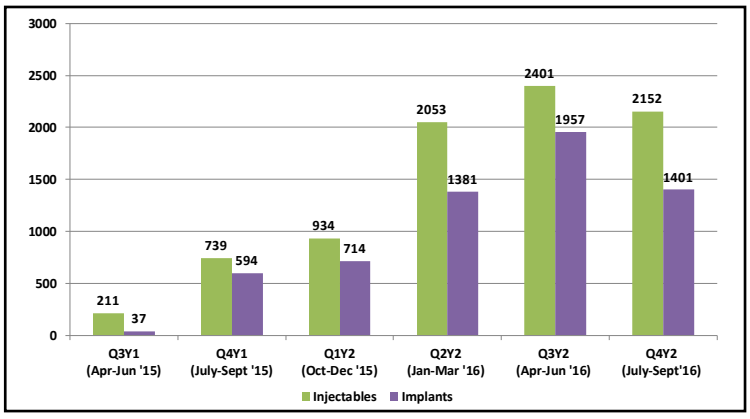
Graph 1: Over the period of 18 months, CBDs counseled 185,554 women and 109,810 men on family planning, with the majority (80%) of clients being adults 20 years and older.

Graph 2: This project introduced couples counseling for the first time in target communities. Although during daytime household visits CBDs had difficulty finding men and women at home together, they made significant effort to counsel over 40,000 couples by the end of the 18 months. This graph represents only couples counseled for the first time. CBDs then followed up with the couples with continued counseling visits.

Graph 3: Contraceptive methods distributed by CBDs



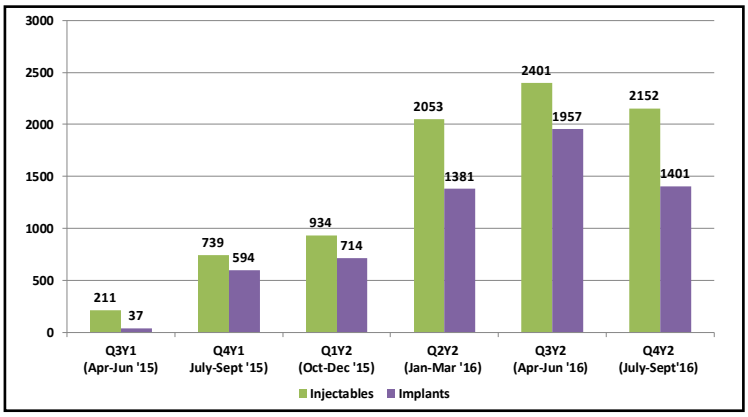
Graph 4: Injectables and implants distributed by nurses at outreach events



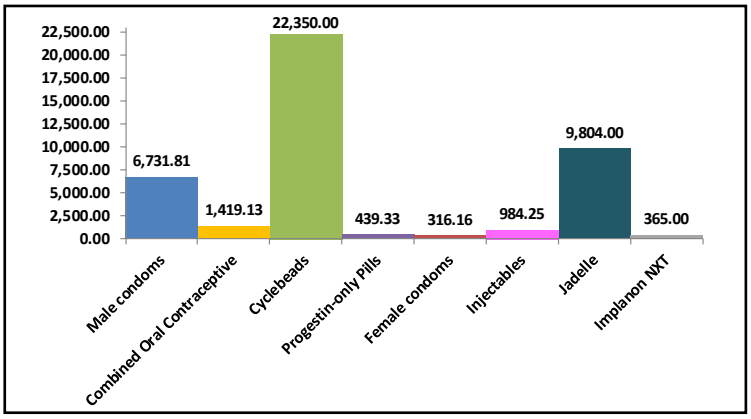
Graph 3 and 4: Although over time there was an increasing number of different methods provided, overall, male condoms far outweighed any other family planning methods distributed by CBDs. Over time, there has been an increasing demand for injectables (DMPA) and implants (Jadelle and Implanon NXT), which are provided through regular, bimonthly outreach events by nurses from nearby health facilities.

Results (Contd)

Graph 5: New family planning acceptors reached by type of provider



Graph 6: Couple Years of Protection generated through different contraceptive methods



Graph 5: A total of 103,932 new acceptors (91,681 by CBDs and 12,251 by nurses during outreaches) were not provided contraceptives over the first 18 months of program implementation.

Graph 6: Over the first 18 months of implementation, the program generated a total of 42,410 Couple Years of Protection (CYP), with the most significant contributions from Cyclebeads and Jadelle.

Community-based distributors explaining oral contraceptives at an outreach event

Challenges

Commodities and supplies: The size of DRC, the demography of the country, which is largely rural, and poor roads and infrastructure challenge the delivery of health services. E2A has strengthened existing systems to ensure commodities, including contraceptives, and oral rehydration salts and zinc to treat childhood dehydration, are available in remote locations. As health staff and officials who have been trained by E2A in stock management and forecasting turnover from their positions, the National Reproductive Health Program, supported by provincial and zonal health offices, will need to ensure sufficient capacities are in place to monitor and forecast for essential supplies, including contraceptives, in order to prevent stock-outs.

Gender norms: In many places across DRC, gender norms are deeply entrenched. Although the program has seen some shifts around attitudes and norms related to gender, it will take more time and effort to realize and measure true change. Female CBDs and CODESA members give women a public voice and are a main vehicle for reaching women with family planning services. Because women look to their male partners to make fertility decisions, however, it will be important to continue efforts to engage men that have been initiated by the program. These efforts should include couples counseling, group sensitizations by religious and community leaders, and public discussions held by male CBDs about family planning and women's empowerment.

Reaching youth: National guidelines in DRC advise that youth receive counseling on the full range of contraceptives, excluding permanent methods, however, program results show that the vast majority of clients—80 percent—reached with family planning counseling were 20 years or older. In the next program year, E2A will focus on working with youth leaders to deliberately target more of their peers and improve trainings with facility-based providers and CBDs on youth-friendly services using the National Plan for Adolescent and Youth Sexual and Reproductive Health.

Lessons Learned

Building on existing systems and involving stakeholders at all levels of government: To design and implement the community-based family planning program in DRC as a scalable model, E2A designed the program using recommendations from a guidance tool, *Beginning with the end in mind*. Application of the recommendations from the ExpandNet guidance has resulted in: government ownership and institutionalization of program interventions and systems at multiple levels (national, provincial, zonal health officials); the creation of complementary service delivery approaches to the current health system using existing resources; and the addition of community-based service delivery indicators to the national Health Management Information System. As program interventions are institutionalized and scaled up, it will be important to sustain the involvement of national, provincial, and zonal health officials to ensure ownership and support for interventions across the decentralized health system and to ensure interventions reach the hardest-to-reach populations.

Innovative approach to community-based distribution in absence of national task-sharing policy: To reach rural populations in DRC with family planning services, it is essential to meet people at the places they already spend time: in their homes, at spots where they hang out after work, at markets and other public meeting spaces. The program has engaged health volunteers, already known and trusted by their communities, to do just that. They work alongside a menagerie of other community agents and leaders to build demand and trust for family planning services in their communities. Nurses have been engaged to meet rising demand for contraception, particularly for clinical contraceptive methods. Outreach events, where nurses accompany CBDs to communities to provide clinical methods in a private setting, is an innovative approach that reaches rural women with a full range of contraceptive options in the absence of a national task-sharing policy. At these events, all community-based and facility-based providers are supported by a health management team from their health zone. This approach leverages existing financial and human resources to increase the chance of sustainability and scale in the three intervention provinces and beyond.

Looking Forward

The collaborative program design process has instituted systems at all levels of government that may contribute to sustainability and scale of program interventions beyond the end date of the program. IHP is already starting to engage CBDs in up to 93 additional health areas in the three provinces, following the model designed by E2A. The vast majority of health zones have added family planning interventions to their annual work plans, and structures have been established for regular review, coordination, supervision, and oversight between provincial and zonal health officials. The National Program for Reproductive Health has added indicators for community-based outreach and family planning services into the national Health Management Information System.

Over the next year, E2A is planning to enhance some of the community-based

interventions by engaging youth leaders to generate demand for family planning services among youth and increase acceptance of youth using family planning methods among community leaders and other household influencers. In terms of gender, E2A is continuing to work with the National Reproductive Health Program to strengthen gender issues within family planning materials, such as job aids and promotional brochures, and to finalize a gender training guide to build provider understanding and response to gender-related barriers to health. E2A is also supporting dissemination of key gender-related policies, such as the National Policy for the Integration of Gender, the Promotion of the Family and the Protection of Children, and the new family code, completed on July 15, 2016.

Regarding the expansion of contraceptive choices offered in communities, E2A is in discussions with Tulane University about piloting Sayana Press within the contraceptive choices offered by CBDs already engaged by the E2A program. E2A has also adjusted the way it collects data to include Lactational Amenorrhea Method in the methods measured by the program.

Young woman in DRC showing off her new implant

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