CROSS RIVER STATE, NIGERIA

Facilitators and Barriers to Systematically Scaling-up Family Planning Task-Shifting and Task-Sharing of Contraceptive Implants

Closing a Critical Gap to Improve Maternal and Reproductive Health

In Nigeria, a shortage in human resources for health—fewer than two nurses and doctors per 1,000 people, with a notable lack of skilled birth attendants—contributes to poor health and development outcomes.

In 2014, recognizing the potential to mitigate the impact of this shortage and improve accessibility and cost effectiveness within the health system, Nigeria adopted its new *Task Shifting and Task Sharing Policy for Emergency Obstetric and Newborn Care Services In Nigeria* (TSTS). This policy would make contraceptive services previously delivered by physicians, nurses, and midwives—namely the provision of implant and injectable contraceptives in addition to short-acting, nonclinical family planning methods—available through community health extension workers (CHEWs), who reside and work in their communities and provide basic components of primary health care.

With technical support from E2A and Pathfinder International Nigeria, Cross River State (CRS) operationalized the National Family Planning (FP) TSTS Policy through the Saving Mothers, Giving Life (SMGL) Initiative. SMGL, which aims to accelerate reduction of maternal and neonatal morbidity and mortality, was implemented from 2015 to 2019 in partnership with the government of CRS. Through SMGL, the Evidence to Action (E2A) Project and Pathfinder International provided technical support, conducted operations research, and supported the development of a strategic scale-up plan to adopt the national FP TSTS policy within CRS. This brief addresses the barriers and facilitators E2A identified to scaling up the state's TSTS policy to allow CHEWs to provide implants.

LAYING THE FOUNDATION FOR SCALE-UP

From 2015–2016, in each of the 18 local government areas (LGAs) where the SMGL operates, CHEWs were trained in at least one public sector facility to deliver a range of quality contraceptive services, including the provision of implants, a long-acting reversible contraceptive (LARC). Operations research[1] was conducted to determine the feasibility of task-shifting the provision of implants and injectable contraceptives to CHEWs at the community level in CRS and Kaduna state. Research showed:

- Improved or highly competent implant counseling skills among CHEWs,
- Strong implant insertion skills among CHEWs, and
- Improved client satisfaction.

Armed with the evidence generated from the operations research and in partnership with development partners—WHO, Population Council, and Global Health Workforce Alliance

1 USAID, E2A, Pathfinder International. *Building Evidence to Support the Provision of Implants at Community Level through Task-Sharing Operations Research, Kaduna and Cross River States, Nigeria.* Policy Brief. 2017.

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Canada the Cross River State government adopted its TSTS policy in 2016. Tailored to meet the state's unique needs related to human resources for health, the policy expanded the role of CHEWs—to include the provision of all family planning services, except intrauterine device insertions and permanent methods. Now with the policy in place, Pathfinder and E2A provided technical assistance to government stakeholders at the state and local levels to set up a resource team and implement an effective scale-up strategy based on the WHO and ExpandNet nine-step approach to scale-up.[1] The scale-up strategy included high priority recommendations to train an 14 additional master trainers and conduct stepdown training for CHEWs with a focus on one functional primary health center (PHC) per ward to cover all LGAs in the state. The full strategy and analysis of level of completion are in the full report.

SCALE-UP LEARNING

In 2018, E2A conducted a study to document the experience of planning and managing the effort to operationalize and scale up the family planning TSTS policy in Cross River State that was implemented from 2017 to 2019.

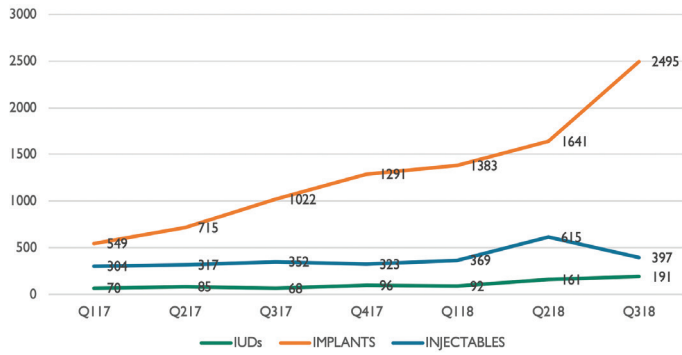
The study team conducted 12 focus group discussions (FGDs) and 10 key informant interviews to gain detailed insights on perceptions of stakeholders involved in the implementation of the FP task-shifting scale-up efforts. To complement the qualitative data, routine service statistics were collected from SMGL routine monitoring statistics and the state health management information system, as well as State Ministry of Health (SMOH) training dashboard and records. SMOH and E2A/Pathfinder trained 160 CHEWs from SMGL sites to provide LARCs. The data show increased acceptance and uptake of FP methods—including implants—from July 2017 to September 2018, the period during which CHEWs provided implants in these sites. From qualitative reports, many respondents noted that they observed an increase in women in their communities seeking FP services, perhaps linked to CHEWs' improved capacities in FP counseling and increased community confidence in CHEWs. The full technical report elaborates on these data. This brief focuses on facilitators and barriers to scale-up.

1 WHO, ExpandNet, Nine Steps for Developing a Scaling-Up Strategy, 2010.

FOUR PILLARS OF FAMILY PLANNING TASK-SHIFTING AND TASK-SHARING SCALE-UP STRATEGY

1	TRAINING CHEWS IN IMPLANT INSERTION
2	COMMUNITY MOBILIZATION TO RAISE AWARENESS OF LARCS AND GENERATE DEMAND FOR FP SERVICES AT COMMUNITY LEVEL
3	SUPPORTIVE SUPERVISION TO ENSURE QUALITY OF CHEWS' LARC SERVICE DELIVERY
4	COMMODITY SECURITY TO ENSURE ADEQUATE CONTRACEPTIVE COMMODITIES AND ASSOCIATED CONSUMABLES FOR LARC SERVICE DELIVERY BY CHEWS

FIGURE 1: NUMBER OF LARC USERS IN THE LGAS, BY METHOD, IN 2017 AND FIRST THREE QUARTERS OF 2018



FINDINGS

Through focus group discussions and interviews, study participants identified facilitators and barriers to scaling up the family planning TSTS, organized by four pillars identified during the systematic scale-up strategy development process. Key responses are highlighted below.

"I learnt so much because the training has helped me, now I can do counselling, have the patient make informed decision and perform the insertion properly, sterilize [medical instruments] as well as … keep records of my activities because we were taught how to document our activities."

—TRAINED CHEW FGD, NORTH

Implant Training

To begin operationalizing the FP TSTS policy, the SMOH and SMGL identified a pool of master trainers in the state to provide stepdown training, mentorship, and supervision for CHEWs. After the training of trainers, these master trainers built the skills of CHEWs, as well as community health officers, who had been in service for at least three years and presented their certificate to practice implant provision. Most CHEW respondents noted the stepdown training was very useful and improved the quality of FP and implant service delivery. Initially, only CHEWs in SMGL-supported sites were trained in implant provision, resulting in fewer than 10 percent of CHEWs in the state receiving training.

"We are closer to the community—they welcome the services and we live with them … The doctors don't live there in the community. [Clients] bring all their problems to the CHEWs … They are not afraid of us. We have a good relationship with them."

—TRAINED CHEW FGD, SOUTH

Training two CHEWs per ward, as recommended in the scale-up strategy, is viewed by some FP supervisors as insufficient for meeting the increased demand for implant services in the various wards in their LGA, resulting in some wards being underserved. Additionally, the majority of the trainers/supervisors and a few policymakers expressed concern about CHEWs' capacity to successfully provide implants. While some CHEWs gained the required skills and competencies and began successfully providing implants, reports from supervisory visits indicated that others were deemed incapable and/or untrainable. Finally, there was insufficient clarity at all levels concerning certification of CHEWs trained in implant provision.

Community Mobilization

CHEWs carried out community mobilization and demand generation as part of their duties by going from house to house or by working with existing community facilitators, such as town announcers, women leaders, religious leaders, and youth leaders. Some of the CHEWs and FP supervisors noted that the implant training had significantly improved CHEWs' FP counseling and health education skills, allowing CHEWs to speak confidently about FP and effectively address misconceptions about FP use. CHEWs expressed that they leveraged their new skills to conduct outreach on market days to more effectively provide an integrated FP and basic preventive health care package.

While SMGL supported some community mobilization activities, non-SMGL sites received limited support from other partners and the government. CHEWs in all sites reported that they had resorted to using their own personal funds to conduct outreaches and community mobilization, and some charged clients for services that were meant to be free to recover their costs. While the training received by CHEWs helped reduce community-level resistance to FP, CHEWs observed that myths and misconceptions persist around FP, in some cases limiting their abilities to provide FP services. CHEWs also cited issues related to gender inequalities and unequal gender norms as a barrier to women accessing FP services, and perceived husbands as a significant barrier. For instance, some CHEWs reported that men demanded they remove their wives' implants, and CHEWs were afraid men would physically harm them if they did not.

Supervision

The scale-up plan included monthly supportive supervision sessions for trained CHEWs and the establishment of peer-to-peer mentoring. With financial and technical support from E2A/Pathfinder, state FP supervisors carried out supportive supervisory visits for CHEWs trained to provide implants, using a monitoring checklist based on the strategic plan for FP TSTS scale-up in CRS. Many respondents (policymakers, implementers, trainers, and FP supervisors) reported that trained CHEWs required additional training and needed to be closely mentored with more frequent supportive supervision to ensure quality of care is maintained. Most implementers, including policymakers, felt the supervision provided was inadequate or unevenly distributed, favoring some LGAs more than others. Respondents (policymakers, implementers, trainers, and FP supervisors) identified limited funding from the state, low number of supervisors, and overdependence on development partners as potential causes of the poor supervision. Certification of CHEWs is also an issue, as the current threshold requires supervisors to observe ten insertions, which can be logistically infeasible due to the frequency of supervisory visits and number of women requesting implants at a CHEW facility.

Commodity Security

The federal government, with support from UNFPA, is currently in charge of the procurement of FP commodities in Nigeria. Commodities are procured nationally, supplied to zonal stores (i.e., CRS for the South-South geographical zone), and distributed by a third-party logistics company, usually without accompanying consumables. Implant stockouts have led to loss of clients. Facilities without consumables have to resort to charging clients for these supplies. The scale-up strategy included recommendations to integrate the FP commodities and consumables into the central commodities purchasing and distribution system and to use existing state tools to document FP logistics management.

Stakeholders' Views of TSTS Policy

Most trainers, supervisors, and policymakers embraced the TSTS policy and saw it as a necessary stopgap mechanism to address the chronic shortage of health workers in the state. Some policymakers, however, vehemently opposed the implementation of the TSTS policy because they felt that CHEWs were favored over nurses, and raised significant concerns over the quality of care CHEWs could provide. Some nurses felt threatened by the TSTS policy, while others believed the TSTS had some advantages. For example, tasks could be shared with CHEWs due to the shortage of nurses in the LGAs. They felt some CHEWs who had been in service longer than the nurses and in charge of these facilities did not allow them to perform their tasks optimally and were not willing to take feedback from the nurses. Some of the respondents further

"I think [TSTS] is very important and appropriate at this time—when we have a dearth of health care workers … We cannot expect that because we don't have enough doctors and nurses, we will not train the personnel we have to handle cases, or that our mothers should die … So, I just think it is the best we can do considering the circumstances we find ourselves in."

—HEALTH POLICYMAKER, SMOH

perceived that the CHEWs were threatened by the presence of nurses in their facilities and tried to make nurses irrelevant in the facilities.

The CHEWs interviewed expressed varied views about friction with other health professionals. Some enjoyed a good working relationship with nurses, while others stressed that friction persists between the CHEWs and nurses. Some CHEWs felt that nurses and doctors looked down on them, making them feel inferior to other health professionals. Some nurses went as far as locking up commodities and preventing CHEWs from observing them perform technical procedures.

RECOMMENDATIONS

Based on feedback from respondents and their sustainability concerns, the following actions were identified that will help the SMOH to institutionalize and systematically scale up TSTS:

1. **Reconfigure the resource team with key government stakeholders** to address perceptions that the resource team was led by E2A, advocate for release of governmental funds, work with professional bodies to address inter-professional conflict between nurses and CHEWs, and write and agree upon a plan to ensure a constant and even distribution of commodities and consumables to meet increased demand for FP.

2. **Adopt a decentralized, LGA-based stepdown training approach supervised by the state**, rather than a state-based approach, to plan and train the number of CHEWs needed to provide implants. This would allow more women to access implants, where CHEWs are the only providers, in a cost-effective and efficient manner. Other recommendations include expanding trainings to more CHEWs, selecting CHEWs based on clearly defined and published criteria, training and retraining CHEWs with particular attention to implant removal, redefining training process to ensure greater competency and reduce the need for supervisory visits, and redefining the CHEW certification process at the state level to cut down number of supervised visits from 10 to a more feasible figure.

3. **Ensure a strong quality control plan** to prevent, respond to, and mitigate unexpected negative consequences, maintain quality standards, and set up a peer-to-peer mentoring system, as recommended in the scale-up strategy, so CHEWs who are found to be competent could mentor CHEWs who are still finding the procedure challenging.

4. **Commit state funding from the Saving One Million Lives (SOML) FP component to train CHEWs and continue scaling-up TSTS** of implant services through increased government ownership, fiscal involvement, and reduced dependence on partners.

Scaling up task-shifting FP to CHEWs requires strong political and resource support for institutionalization within state systems. By working with the facilitators, addressing the barriers identified through this research, and implementing the key recommendations, the SMOH can expand the number of CHEWs trained, improve the quality of counseling and service provided, and increase the number of women with access to implants.

The Evidence to Action (E2A) Project 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. The project is led by Pathfinder International, in partnership with ExpandNet, IntraHealth International, Management Sciences for Health, and PATH. **e2aproject.org**

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