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# Lessons Learned from the Systematic Scale-Up of Family Planning Task-Shifting and Task-Sharing in Cross River State, Nigeria

REPORT | E2A PROJECT



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## ACRONYMS AND ABBREVIATIONS

BWEIM	Beginning with the End in Mind
CHEW	Community health extension worker
CBO	Community-based organization
CHO	Community health officer
CRS	Cross River State
E2A	Evidence to Action
FGD	Focus group discussion
FMOH	Federal Ministry of Health
FP	Family planning
ILMD	Integrated Last Mile Distribution
KII	Key informant interview
LARC	Long-acting reversible contraceptive
LGA	Local government area
M&E	Monitoring and evaluation
MSI	Marie Stopes International
MWAN	Medical Women Association of Nigeria
OR	Operations research
PHC	Primary health care
PHCDA	Primary Health Care Development Agency
RT	Resource team
SDG	Sustainable development goal
SOML	Saving One Million Lives
SMGL	Saving Mothers, Giving Life
SMOH	State Ministry of Health
TOT	Training of trainers
TSTS	Task-shifting and task-sharing
UNFPA	United Nations Population Fund
WHO	World Health Organization

# EXECUTIVE SUMMARY

## Background

Human resource shortages in the health services are widely recognized as a threat to the attainment of the health-related sustainable development goals (SDGs), including reduction of maternal mortality. A more rational distribution of tasks and responsibilities among health worker cadres has the potential to improve accessibility and cost effectiveness within health systems and to mitigate the impact of the health worker shortage. Nigeria's national Task Shifting and Task Sharing (TSTS) policy, approved in 2014, allows Community health extension workers (CHEWs) to provide long-acting family planning methods, including implants, in addition to short-acting, non-clinical methods, thus helping to ease the burden on facility-based providers and increasing accessibility to more rural areas.

With technical support from the Evidence to Action (E2A) Project and Pathfinder International Nigeria, Cross River State (CRS) operationalized the National Family Planning (FP) TSTS Policy through the Saving Mothers, Giving Life (SMGL) Initiative. Through SMGL, Pathfinder and E2A trained CHEWs to provide contraceptive implants, conducted operations research to assess the feasibility of task-shifting the provision of implants to the community level in CRS and Kaduna state, and provided support to the CRS government to develop and implement a TSTS scale-up strategy. During the scale-up strategy development process, four pillars were identified as essential components of the innovation for the scale-up process: training, community mobilization, supportive supervision and commodity security. Building on these pillars, since 2017 E2A and Pathfinder Nigeria have provided technical assistance to CRS stakeholders at the state and local government levels to implement the strategy for systematic scale-up of task-sharing family planning services—with a particular focus on implant provision.

Based on the collection of both qualitative and secondary quantitative data, this paper documents the experience of planning and managing the effort to operationalize and scale up the family planning task-sharing/task-shifting policy in Cross River State from 2017 to 2018. The purpose of the report is to provide actionable information on how to improve task-shifting scale-up.

## Results: Facilitators and Barriers to Scale-Up

### LARC Training

The Ministry of Health and SMGL identified a pool of master trainers in the state to provide stepdown training, mentorship, and supervision for CHEWs. Most CHEW respondents noted that the stepdown training on LARCs was very useful and improved the quality of FP service delivery, particularly for implants. However, despite efforts by Pathfinder and SMOH to scale up TSTS of implant services in CRS, fewer than 10% of CHEWs in the state have received training on implant provision. The number trained is viewed by some FP supervisors as incapable of 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 the CHEWs' capacity to successfully provide implants. Finally, there is insufficient clarity at all levels concerning certification of CHEWs trained in implant provision.

### Community Mobilization

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

### Supervision

Supportive supervisory visits for CHEWs trained to provide implants were carried out by the state, with financial and technical support from Pathfinder, using a monitoring checklist and based on the strategic plan for FP TSTS scale-up in CRS. Many respondents (policymakers, implementers, trainers, and FP supervisors) reported that the trained CHEWs required additional training and needed to be closely monitored with more frequent supportive supervision to ensure that quality of care is maintained. Most implementers, including policymakers, felt that the supervision and mentoring provided were inadequate or unevenly distributed, favoring some LGAs more than others. Respondents reported that limited funding from the state, inadequate staffing, and overdependence on development partners were potential causes of the poor supervision.

### Commodity Security

The federal government, with support from UNFPA, is currently in charge of the procurement and supply of FP commodities in Nigeria. Commodities are procured nationally, supplied to zones, and distributed by a third-party logistics company, usually without accompanying consumables. Implant stockouts have led to loss of clients and facilities without consumables have resorted to charging clients for these supplies.

### 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 nurses were not being hired in favor of CHEWs and raised significant concerns over the quality of care CHEWs could provide. Some nurses felt threatened by the TSTS policy, while others believed that the TSTS had some advantages and that tasks could be shared with CHEWs due to the shortage of nurses in the LGAs. Their main concerns were the fact that some of the 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 perceived that the CHEWs were threatened by the presence of nurses in their facilities and tried to make them irrelevant in the facilities. Additionally, many nurses and policymakers expressed concern with the trained CHEWs' quality of service delivery as well as the provision of LARCs by untrained CHEWs. 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.

## **Quantitative Results**

There was a four-fold increase in implant acceptors in the local government areas (LGAs) over the period in which CHEWs were trained to provide implants. During discussions and interviews with CHEWs, FP managers, and community members, most respondents expressed that they had observed increased acceptance and uptake of family planning methods (especially implants). Many discussants reported that they observed an increase in women of reproductive age in their communities independently seeking FP services, linked to greater awareness of FP in the communities; the fact that many commonly held misconceptions about FP had been corrected by CHEWs and other service providers, who provided adequate information regarding FP; improved FP counseling skills among CHEWs; and improved communication about the advantages associated with implant use. The long-acting reversal contraceptive (LARC) training received by CHEWs was perceived as giving a significant boost to the primary health care (PHC) facilities, which were previously underutilized.

## **Concerns About Sustainability**

While many elements of the scale-up strategy were implemented and facilitators to scale-up were identified, concerns about sustainability of TSTS of implant services remain. Institutionalization of scale-up activities, such as ensuring enough trainers per LGA to train CHEWs, relies on government ownership and sustainable funding. Many respondents feared that weak political will and lack of government ownership would be a challenge to the FP TSTS scale-up efforts after the end of SMGL. A potential reason for this lack of ownership was the perception of the TSTS scale-up effort as a Pathfinder project. The composition of the resource team and centralization of power in the chairs, who were closely associated with Pathfinder, contributed to this perception.

Another significant concern was the consistent lack of government commitment and poor funding of FP-related programs by the government over the years. Policymakers stressed that most achievements in FP service delivery had been with the support of partners and even where governmental budget lines exist for FP, funds have not been released. The paucity of funding has contributed to lack of consumables in many facilities; exorbitant or unnecessary charges to clients accessing these services; reduced demand for implants, if outreach services aimed at generating demand are not conducted regularly; poor quality of care; inadequate supervision of CHEWs; and overdependence on partners' support. Some stakeholders expressed concern that achievements associated with the LARC training and task-shifting may be reversed if partners withdraw their support.

## Conclusions and Recommendations

The expansion of the roles of CHEWs to include implant service provision has been described as a worthy and timely intervention to address unmet need for FP in CRS. Based on recommendations from participants and their sustainability concerns, potential steps were identified to institutionalize TSTS and systematically scale up.

1. Reconfigure the resource team with key government stakeholders to address perceptions that the resource team was led by E2A/Pathfinder, 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 and fiscal involvement and reduced dependence on partners.
5. Improve demand generation activities, particularly in hard-to-reach communities, including male engagement and community social and behavior change components to complement expanded services.

Scaling up task-shifting FP to CHEWs requires strong political and resource support for institutionalization within state systems. By working with the facilitators and 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 counselling and service provided, and increase the number of women with access to implants.

# INTRODUCTION

## Task-Shifting and Task-Sharing

Human resource shortages in the health services are widely recognized as a threat to the attainment of the health-related Sustainable Development Goals (SDGs).<sup>1</sup> The shortage of well-trained health workers is a global dilemma that is not limited to, but worst in, low- and middle-income countries, including Nigeria. Although Africa is made up of about 11% of the world's population (with consistently high mortality rates), the continent accounts for about a quarter of the global burden of disease and has only 4% of the global health workforce to tackle this problem.<sup>2</sup> Countries such as Ghana, Nigeria, Zambia, and South Africa, whose health care systems are considered better relative to the rest of the continent, have already over-stretched their health systems due, in part, to health worker shortages in rural areas.<sup>3</sup> Attempts to optimize the potential of the existing health workforce are therefore crucial. A more rational distribution of tasks and responsibilities among health worker cadres has the potential to improve accessibility and cost effectiveness within health systems and to mitigate the impact of the health worker shortage. In response to policymaker's interest in tackling the health worker shortages in various countries, the World Health Organization (WHO) encourages task-shifting.

Nigeria's Task Shifting and Task Sharing (TSTS) policy defines task-shifting and task-sharing as "the rational redistribution of tasks among health workforce teams. Specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make more efficient use of the available human resources for health."<sup>4</sup> The goal of task-shifting or sharing is simply "to get the right workers with the right skills in the right places doing the right things."<sup>5</sup> Task-shifting has been used in several countries to address the human resource shortages that threaten the provision of critical services like HIV testing and treatment with antiretroviral drugs or community distribution of injectable contraceptives. Some African countries, including Uganda, have demonstrated the feasibility and effectiveness of using task-shifting to deliver injectable contraceptives by community health workers and people living with HIV and AIDS.<sup>6</sup>

## Rationale for TSTS in Nigeria

In Nigeria, health and development indicators are generally unsatisfactory and are termed some of the poorest in the world, contributing over 14% to the global maternal mortality burden, or approximately 358,000 maternal deaths per year.<sup>7</sup> Sexual activity and motherhood begin early, with 18% of adolescent girls having started childbearing in Cross River State (CRS).<sup>8</sup> Studies in Nigeria and globally show that adolescent pregnancy is associated with higher morbidity and mortality for both the mother and the child<sup>9</sup> - particular concerns in the South-South geopolitical zone (where CRS is located), where nearly half (48%) of all pregnant women aged 15-24 are expecting their first child. Poor maternal health indices have been linked to shortages in human resources for health in the country, characterized by a shortage of skilled birth attendants and worsened by a distribution of the available cadres that is skewed in favor of urban locations in the Southern states. Other factors responsible for this shortage include a halt on employment in the public service of some states in the country, leading to a pool of trained unemployed health professionals; poor



working environments, which have led to external and internal brain drain to other professions; low motivation, attraction, and retention; high attrition rates; and high rates of absenteeism and poor performance. This shortage has further been compounded by the number of older health care workers who have retired in recent years or who are due to retire without replacements, as observed in CRS.

Task-shifting/sharing policies therefore constitute a temporary measure to mitigate the health workforce shortage by shifting some tasks to other health care workers who can be trained to competency and given specific responsibilities for the care of vulnerable people, especially in remote areas. Community health workers reside and work in most communities, including those without a stable health workforce, and Nigeria has therefore begun task-shifting from physicians, nurses, and midwives to community health extension workers (CHEWs), who typically provide basic components of primary health care (e.g., immunization services, antenatal care, treatment of minor ailments, and growth monitoring).

### **Piloting TSTS in Cross River State (2015–2016)**

The Nigerian National Council on Health held a meeting in Akwa Ibom state in 2014 which resulted in the approval of the National TSTS Policy that permits CHEWs to offer all contraceptive services (except for permanent methods). Previously, CHEWs had only been able to provide short-acting, non-clinical family planning (FP) methods. This new national policy allows CHEWs to provide implants and injectables. However, implementation is decided on and carried out at the state level and states have been slow to operationalize the task-sharing policy. In 2016, only 10 of the country's 36 states were implementing the policy: five states from the South-south geo-political zone (Cross River, Akwa Ibom, Bayelsa, Rivers, and Delta), three from the North West (Kaduna, Kano, and Zamfara), one from South East (Ebonyi), and one from the South Western zone (Ondo).

With technical support from the Evidence to Action (E2A) Project and Pathfinder International Nigeria, Cross River State (CRS) operationalized the National FP TSTS Policy through the Saving Mothers, Giving Life (SMGL) Initiative. SMGL, which aimed 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, Pathfinder and E2A trained 40 CHEWs (two CHEWs each from 20 intervention facilities) to provide contraceptive implants and, from 2015 to 2016, conducted operations research to assess the feasibility of task-shifting the provision of contraceptive implants to the community level in CRS and Kaduna state.<sup>10</sup>

The operations research on the TSTS pilot showed improved or highly competent implant counseling skills among CHEWs, strong implant insertion skills among CHEWs, and improved client satisfaction from baseline to endline. However, although the trained CHEWs provided greater numbers of implants over time, the total number of clients requesting implants did not increase overall in facilities, indicating that, while the task of implant provision could be shifted successfully, task-shifting did not result in increased FP uptake. This could be due to the nature of the intervention, which did not include demand generation activities. Results of the 2015-16 operations research indicated that, for TSTS to be successfully scaled up, greater attention needed to be paid to: demand generation activities both within facilities and communities, periodic training and refresher training of CHEWs on implant service provision; supportive supervision for and maintenance of

quality assurance; consistent supply chain and commodity logistics support at the facility level; and health system support or strengthening more generally. Although the research demonstrated that providing contraceptive implants can be safely task-shifted to less highly trained workers and that doing so could be a crucial means of expanding access to contraceptive implants, it is clear that task-shifting alone does not lead to effective implementation at scale and that other accompanying interventions were equally necessary.

### **Adoption of the National TSTS Policy at State Level in CRS (2016–2017)**

The evidence generated in the 2015-16 operations research contributed to the subsequent adoption and adaptation of the TSTS policy in CRS in November 2016. The state government, through the Ministry of Health, worked with development partners (WHO, Population Council, and Global Health Workforce Alliance Canada) and other stakeholders to adapt the National TSTS Policy to suit the unique human resources for health needs of the state (see Appendix 1 for list of partners involved in FP service delivery in CRS). The CRS TSTS Policy was intended to increase the capacity and number of health workers who can provide essential health service packages, particularly in Family and Reproductive Health, Maternal and Child Health, HIV, Malaria, and Tuberculosis, in an effort to significantly reduce the infant and maternal mortality rates in the state. For the purposes of FP service delivery, the state TSTS policy expanded the role of CHEWs to include delivery of all FP services except intrauterine device (IUD) insertions and permanent methods. The process of adapting the TSTS policy to CRS began in 2016 and was completed in 2017. The policy document “Cross River State Ministry of Health Task Shifting/Sharing Policy for Essential Services” was launched officially in August 2017 during the State Maiden Health summit meeting.

### **Scaling up TSTS in Cross River State (2017–2019)**

Systematic scale-up is defined by ExpandNet 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.”<sup>11</sup> A key task of E2A, a consortium whose members include Pathfinder and ExpandNet, is to provide technical leadership in scale-up through supporting and documenting scale-up approaches and supporting their adoption by countries and organizations. Since the passage of the task-sharing/shifting policy in Nigeria in 2014, E2A has been providing technical assistance to scale up the task-sharing of implant provision by CHEWs in Cross River State, beginning by supporting the operations research described above.

Additionally, Pathfinder Nigeria and E2A supported a process of strategic planning for and managing the scale-up of the task-shifting/sharing policy using ExpandNet’s nine-step approach. As part of the development of the scale-up strategic plan in February 2017, a state-level resource team was set up to coordinate and guide the scale-up process for FP task-sharing interventions in the state. The resource team was composed of a wide variety of stakeholders, although participation of several has been inconsistent, as described below. Since 2017, E2A and Pathfinder Nigeria have provided technical assistance to CRS stakeholders at the state and local government levels to implement the strategy for systematic scale-up of task-sharing family planning services—with a particular focus on implant provision—by CHEWs.

## STUDYING THE SCALE-UP OF FAMILY PLANNING TASK-SHIFTING, TASK-SHARING IN CRS

This study aims to document the experience of planning and managing the effort to operationalize and scale up the family planning task-sharing/task-shifting policy in Cross River State from 2017 to 2018. This study documents:

- The process of developing a scale-up strategy for FP TSTS in CRS
- Results of implementation of the FP TSTS scale-up strategy
- Impact of TSTS on FP service delivery and service use
- Factors that inhibited or fostered successful scale-up and sustainability of FP TSTS
- Lessons learned and recommendations for moving forward with task-shifting/sharing of FP services in Cross River State.

### Study Setting

The study was conducted in Cross River State, one of the 36 states located in Nigeria's South–South geopolitical zone. CRS has 18 local government areas (LGAs) spread across three senatorial districts—North, Central, and South. All LGAs in the state are currently implementing the FP TSTS Policy to some degree. With support from Pathfinder and other partners, CHEWs in at least one public sector facility in each of the LGAs have been trained on delivery of long-acting and reversible contraceptives (LARCs). In Cross River State, there are currently 1,000 primary health facilities (968 of which are functional), 152 secondary facilities (130 private and 22 public), and 2 tertiary health facilities. The local government is responsible for primary health care, the state for secondary health care, and the national government for tertiary care, as well as formulation of policies and provision of directives that are managed through the Federal Ministry of Health in Abuja.

This study was conducted at the primary and secondary levels: data from health care providers (CHEWs and nurses), supervisors, and community influencers were collected at the LGA level and data from policy makers, state trainers and supervisors, and other stakeholders at the secondary level. No data were collected from the tertiary, or national, level.

### Study Design

This was a case study to document FP task-shifting scale-up efforts in CRS and the outcomes thereof through the collection of both qualitative and secondary quantitative data. Qualitative data was collected through focus group discussions (FGDs) and key informant interviews (KIIs). This was complemented by quantitative data gathered from routine service statistics.

## Sample Size / Sampling

### LGA and Facility Choice

LGAs in CRS where FP task-shifting scale-up efforts had already begun were selected for the study. One LGA from each of the three senatorial districts were purposively selected as sites for FGDs (Ogoja, Ikom, and Calabar South). Discussants for these groups were invited from five LGAs surrounding each of the chosen study sites to participate in FGDs (see Appendix 2). This selection was guided by Pathfinder staff in CRS. The criteria for facility selection included: being CHEW-led (i.e., facilities staffed by CHEWs, with no doctors or nurses); having CHEWs who were trained in LARC provision; and CHEWs currently providing implants and injectables in according with the FP TSTS Policy.

### Focus Group Discussions and Key Informant Interviews

A purposive sampling technique was used to recruit participants for both the FGDs and KIs. Stakeholders who had played active roles in the planning or implementation of FP task-shifting scale-up efforts at the different levels of health care delivery and who had the potential to provide rich, relevant, and diverse data pertinent to the study objective were recruited into the study. A total of 10 interviews and 12 FGDs were conducted during the study period.

### Qualitative Data

The principal investigator and five research assistants carried out the qualitative data collection. The research assistants were trained over a period of two days to conduct FGDs, take notes in FGDs and KIs, and carry out data transcription and analysis. The research assistants were actively supervised by the principal investigator to ensure that they collected relevant information in line with the study objectives. Field work for this project was done in two rounds over a two-month period. Each round took place in distinct geographical areas. The first round of data collection was conducted in October 2018 and the second round was conducted in December 2018.

### Focus Group Discussions

The FGDs with service providers aimed at: documenting the experiences of providers following implant provision to clients in their respective communities; identifying gaps in the scalability of the FP task-shifting efforts; and identifying facilitators of LARC service delivery. The FGDs also documented lessons learned and elicited suggestions from the implementers on how to improve the scale-up efforts. The FGDs were carried out among the different groups involved in the implementing of the FP TSTS scale-up strategy in the state, segregated by cadre. CHEWs from the two CHEW-led facilities were invited to participate in FGDs from the fifteen LGAs in the North, Central, and Southern senatorial districts. Based on the inclusion criteria, two trained CHEWs from each LGA were invited to participate in the FGDs. Additionally, untrained CHEWs (CHEWs who have not yet been trained on implant service provision but are currently providing other FP commodities) were invited to participate in FGDs. Health care providers (physicians and nurses) who had previously provided LARCs and other FP commodities were also recruited to participate in the study. Finally,

LGA FP supervisors, trainers, and community influencers were identified in these LGAs from SMGL and non-SMGL sites and invited to participate in separate FGDs (see Appendix 3).

CHEWs were invited to participate through written invitations as well as phone calls, sent with the help of the PHC coordinators in the respective LGAs. SMS reminders were sent to remind them a day before the FGD. Each focus group comprised of 8–10 participants, a moderator, a note taker, and an observer. The FGDs were conducted in a convenient place and time chosen by the discussants. Participants sat around a round table to ensure proper eye contact and attention. The moderator (the principal investigator or a trained senior research assistant) facilitated the discussion and ensured equal participation, following an FGD guide developed by the project. This tool asked questions on demographic and other descriptive information, family planning activities, implant training, and barriers and facilitators to implant delivery (see Appendix 5 for the FGD guide). Permission was sought and obtained from participants to record the discussion. The FGDs were conducted in English or Pidgin English depending on the group's preferences and interpretation was used where needed. Each discussion lasted about 30–60 minutes. Consent to record the session was received from all respondents before conducting the FGD. The number of FGDs was guided by study aims, cadre/sub-groups, study questions, and objectives. These were also guided by practical constraints such as the amount of time available for data collection. A total of 12 FGDs were conducted (see Appendix 3 for number of FGDs per cadre).

### Key Informant Interviews

KIIs were conducted to gain detailed insights on perceptions of stakeholders involved in the implementation of the FP task-shifting scale-up efforts in Cross River State and lessons learned. This was carried out after carefully identifying key players involved in implementation of the FP task-sharing policy in the state (see Appendix 4 for list of interviewees). Members of the Resource Team and User Organizations were the key targets for the interviews. Respondents included stakeholders at the national and state levels of health care delivery, as well as professional bodies involved in funding, planning, managing, implementing, organizing, or advocating for the planning and implementation of scale-up of the FP task-shifting policy in Cross River State.

Interviews were conducted at a convenient time and place, chosen by the interviewee. Interviews were conducted in English using an interviewer guide containing relevant questions (see Appendix 6). The principal investigator conducted the interviews and a note taker took down notes of both verbal and nonverbal responses. Written consent was obtained from all respondents before each interview. Each session was audio recorded after permission had been sought and obtained from the interviewee. The interviews lasted 30–45 minutes (or longer, depending on how much time the interviewee was able to spare for the activity). A total of 10 interviews were conducted.

### Data Management and Analysis

At the end of each interview and FGD, the recorded interview was transcribed verbatim and stored in a separate file bearing the date and place it was conducted, as well as the research questions addressed. Anonymity was ensured as interviews were identified by serial numbers. Electronic files were saved on a password protected computer.

Data gathered from focus group discussions and key informant interviews were analyzed by a team of researchers led by the principal investigator. The analysis was done manually using a framework thematic analysis approach involving four steps: familiarization, indexing/coding, charting, and mapping/interpretation. This approach facilitates the identification of “commonalities and differences in qualitative data, before focusing on relationships between different parts of the data, thereby seeking to draw descriptive and/or explanatory conclusions clustered around themes.”<sup>a</sup>

## Quantitative Data

### Service Statistics

The aim of the quantitative data collection was to document trends in uptake of contraceptive implants in primary care facilities in Cross River State. Data was collected on the following indicators: number of CHEWs in the state; number of CHEWs in the state trained as FP/implant providers; number of implant users served by CHEWs in CHEW-led PHC facilities; number of LARC FP users in the LGAs over time, by method, from baseline period to date; and number of FP commodities, by method, distributed by CHEWs since baseline period to date (January 2017 through September 2018) in CHEW-led PHC facilities.

### Data Management and Analysis

The above indicators were analyzed based on already collected data. These sources were comprised of Pathfinder’s ODS data collection system, the State Ministry of Health (SMOH) training dashboards and records, and health management information system. Two research assistants were trained to participate in the quantitative data collection and analysis. Data were entered into Statistical Package for the Social Sciences (SPSS) version 20.0 and analyzed using descriptive statistics (frequencies and proportions to summarize variables) and displayed graphically using charts (time trend analysis graphs, bar charts, line graphs, and pie charts).

## Study Limitations

The quantitative data reported was mainly from the Pathfinder’s ODS data collection system and the SMOH Dashboard. The HMIS data in the SMOH was of limited use because it did not provide specific data on LARC service provision by CHEWs. Data collected in the HMIS for implants, for example, was not disaggregated by type of health provider delivering the service, which made it difficult to know if it was a CHEW, nurse, or physician who provided the implant. The ODS data system did not disaggregate by type of provider; however, the research team disaggregated data by facilities that were “CHEW-led,” meaning a CHEW directed service provision but could have been supported by nurses or midwives.

Although all FGDs were carried out successfully, there were challenges to completing all the planned KIs—particularly those with national-level development partners. Although interviewees were contacted in writing

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<sup>a</sup> Gale NK, Heath G, Cameron E, Rashid S, Redwood S. Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Med Res Methodol.* 2013;13:117. Published 2013 Sep 18. doi:10.1186/1471-2288-13-117.

and by phone, and had agreed to participate, some interviewees ultimately cancelled due to their busy end-of-year schedules.

All efforts to set up interview appointments proved unsuccessful (including attempts to conduct phone interviews with national stakeholders). This may have skewed the results in favor of state- and local-level stakeholder perspectives.

## DEVELOPING A STRATEGY TO SCALE UP FAMILY PLANNING TASK-SHIFTING, TASK-SHARING

### Systematic Scale-Up

Pathfinder Nigeria and E2A supported a process of strategically planning for and managing the scale-up process using WHO/ExpandNet's *Nine Steps for Developing a Scaling-up Strategy*—a guide that outlines a systematic approach for institutionalizing and expanding innovations that have been successfully tested in pilot projects.<sup>12</sup> According to WHO/ExpandNet, “the innovation refers to health interventions and/or other practices that are being scaled up.... [it can be] a package of interventions, often consisting of several components, or new technologies and the means to provide them, as well as changes in the approach to health service delivery or community interventions.” The project also used WHO/ExpandNet's Beginning with the End in Mind (BWEIM) tool, which is based on the premise that projects should be planned and organized from the beginning to enhance their potential for future large-scale and sustainable impact.<sup>13</sup> The tool proposes 12 recommendations or steps that project implementers and designers should follow to achieve this objective.

### FP TSTS Scale-Up Strategy

A strategic document for the systematic scale-up of the task-sharing family planning services to CHEWs was developed during a five-day workshop carried out in February 2017 in Calabar. The meeting included a 2-day capacity building component where participants were introduced to the WHO/ExpandNet tools used for scale-up, including BWEIM and the nine-step approach. In this process participants analyzed the innovation itself, the organization intending to adopt the innovation, the resource team who will support the scale-up process and the external environment.

The OR results were shared on the third day with a larger group of stakeholders in the state, and the development of the strategy was facilitated by ExpandNet/ E2A using the nine steps approach for systematic scaling up with contributions from invited stakeholders during the latter two days. Seventy persons drawn from State Ministry of Health (SMOH), state Primary Health Care Development Agency (PHCDA), partner organizations, relevant ministries, community-based organizations (CBOs), institutions and nongovernmental organizations (MWAN, Mediatrix Foundation) were in attendance. Participants were divided into groups based on area of competence and asked to work in groups (nine in total) to go through the nine steps. At

the end of the time allotted for the group discussions, the group leader made a presentation on behalf of the group for contribution and further discussions by the scale-up team. At the end of this meeting, a strategic document was developed which assigned roles and responsibilities to relevant stake holders as well as identified key pillars of the scale-up strategy and provided guidance on implementation of the FP task-sharing policy (see Text Box).

The key components of the innovation were training for trainers, nurses/midwives and CHEWs on LARC service provision, establishing quality assurance mechanisms through supportive supervision supportive supervision, commodity security and expanding community mobilization/demand generation. Others key areas were resource mobilization, monitoring and evaluation, stewardship and advocacy for integration and institutionalization of the health innovation.

The consolidated strategy is presented in Appendix 7. Through the Health Commissioner, the Cross River State

government endorsed the Strategic FP Scale-up Plan and the Health Commissioner sent a letter asking that all partners involved in FP service delivery in the state buy into supporting the implementation of the TSTS for FP delivery. Key recommended actions (drawn from the strategy) to achieve vertical and horizontal scale are summarized in Tables 1 and 2 below, along with notes on the progress made to date in implementing these actions.

#### FP Task-shifting/Task-sharing Scale-Up *Key Pillars of the Strategy*

- **Training** CHEWs in implant provision
- **Community mobilization** to raise awareness of LARCs and generate demand for FP services at community level
- **Supportive supervision** to ensure quality of CHEWs' LARC service delivery
- **Commodity security** to ensure adequate contraceptive commodities and associated consumables for LARC service delivery by CHEWs
- Created student-led organization to address turnover in peer leaders



Table 1: Vertical Scale-Up / Institutionalization

Recommended Actions from the Scale-up Strategic Document for Vertical Scale-up	Institutionalization in CRS (vertical scaling up) Achievements
Distribution of the CRS TSTS policy to relevant stakeholders and training institutions which specifically addresses what tasks can be shifted	Achieved
Use of the Federal Ministry of Health (FMOH) CHEW training manual for training	Adopted and used during the step-down trainings or CHEWs
Incorporation of LARC service delivery to be incorporated into pre-service training – revision of the curriculum	Currently ongoing in the state but has since been approved at the National level
Training on FP/LARC service delivery capacity should be incorporated into the pre-service training curriculum for CHEW (College of Health Technology), nursing and midwifery training programs	Tutors from the college of Health technology and school of Nursing/ midwifery were selected and have been trained as LARC trainers in the state
Advocate for the release of FP CHEW training funds which is part of Saving One Million Lives (SOML). budget.	Approval has been received to use the SOML funds for training more CHEWs, but funds are yet to be received by the SMOH
Advocate that the budget line for FP that is currently under MOH needs to be pulled out and separately earmarked for FP and not as a component of the Ministry's budget.	An FP budget line has been secured, but funds are yet to be received
Cluster Model (used by Chemonics) implemented for the 18 LGAs in which LGAs come to the cluster center to receive commodities for distribution	Cluster model is currently being used as well as the Integrated Last Mile Distribution model

Table 2: Horizontal Scale-Up / Geographical Expansion

Recommended Actions from the Scale-up Strategy Document for Horizontal Scale-up	Geographical expansion in CRS (horizontal scale-up) Achievements
Ensure capacities of CHEWs are built to add provision of implants, targeting 1 PHC per ward then neighboring wards	Using the recommended approach of training of 2 CHEWs per ward, so far 149 CHEWs have been trained out of the projected 392 CHEWs (196 wards in CRS). This means less than half of the CHEWs have been trained successfully
Expand the number of CHEWs that can be reached by training and mentoring	This was achieved by expanding the pool of master trainers from 6 to 20
Use a gradual phased implementation approach focusing on One Primary Health Center per Ward (OPHCPW) approach including upgrades of basic medical equipment, identification of confidential space for FP service delivery, IEC materials, commodities, access to training models, etc.	A gradual phased implementation of focusing on 1 PHC per ward approach has been adopted
Demand generation through advocacy and sensitization should be carried out at the community level using the existing community structures like age grade, religious and traditional groups, TBAs etc. Leverage on the monthly meetings of these groups for the discussion	Currently being done using available structures within the community
Ensure availability of training materials and models for demonstration. This should be domiciled in general hospitals while PHCs could obtain and make use of as need arises	With Support from Pathfinder, these materials for training and demonstration are available in health facilities
Monitoring should be intensified at all levels; training, implementation, supportive supervision, FP uptake, and commodity logistics.	Monitoring in CRS is currently being undertaken through monthly supportive supervisory visits, for the trainees to ensure standards are maintained

### Establishing a Resource Team to Support Scale-Up

According to the ExpandNet model, a resource team is “the individuals and organizations that seek to promote and facilitate wider use of the innovation.”<sup>14</sup> A competent, qualified resource team is crucial to successful scale-up. At the February 2017 scale-up strategy development workshop, a resource team (RT) was established with approximately 30 members drawn from relevant ministries, implementing partners, nongovernmental organizations, and CBOs. The RT was assigned the task of promoting and facilitating the wider use of the innovation. The RT is also responsible for providing strategic direction and technical input to the government of CRS in implementing its task-sharing policy, especially in relation to FP, to improve maternal health indices in the state; carrying out advocacy visits to relevant policymakers; expanding the RT

to include relevant stakeholders who play a key role in FP service delivery in CRS; and identifying and proffering solutions to some of the bottlenecks in FP service delivery in CRS. The RT was formally inaugurated by the Health Commissioner of CRS and key stakeholders were chosen to lead the team. The Chair of the Resource team was the Chairman of the Family Planning Advocacy working group, the State FP Coordinator served as the vice chairman, and a Pathfinder CRS staff person was the secretary. The RT received technical assistance and support from E2A. The RT convened a total of five meetings, the last of which was held 31 July 2018.

The RT's first assignment was to review and refine the scale-up strategic document that was a product of the training workshop. The RT produced a concise form of the document for circulation, which was shared (along with the State TSTS Policy) with relevant stakeholders (see Appendix 7).

## IMPLEMENTING THE FAMILY PLANNING TASK-SHIFTING, TASK-SHARING SCALE-UP STRATEGY

During the scale-up strategy development process, four pillars were identified as essential components of the innovation for the scale-up process: training, community mobilization, supportive supervision and commodity security. The state, in close collaboration with Pathfinder, commenced implementation by building on these pillars. This section describes the implementation process by each pillar and adds a final section for stakeholders' view of the scale-up strategy.

### LARC Training

#### Training a Cadre of Master Trainers

**Master trainer selection:** Working with the Ministry of Health, a pool of master trainers in the state were identified to provide stepdown training, mentorship, and supervision for CHEWs. At the beginning of implementation of the FP TSTS scale-up effort, there were only six master trainers, which was inadequate to conduct step-down trainings in all 196 wards. The State, with technical and financial support from Pathfinder, decided to train 14 additional master trainers (four of whom were based in the LGAs), bringing the total number of trainers to 20. The selection process of the 14 trainers was led by the State. The criteria for master trainer selection (determined during the strategy development workshop) included: being a qualified nurse or midwife, having at least three years remaining in service after training, and being competent in provision of implants.

Trainers were drawn from the State Ministry of Health, the State Primary Health Care Development Agency, and training institutions within the state (Colleges of Health Technology and School of Nursing and Midwifery). They were invited for a six-day training of trainers (TOT) workshop. A trainer from the training institution (College of Health Technology) was included to foster institutionalization within the College's pre-service training curriculum, as recommended in the FP task-shifting/sharing scale-up strategy (Appendix 7).

The scale-up strategy proposed using six trainers from each senatorial district, which was not possible due to lack of competent human resources.

**TOT:** The first three days of the TOT were used for classroom teaching using nationally approved FMOH training manuals. The remaining three days consisted of practical skills building sessions using anatomical models and simulations, as well as practicing live insertions on clients from nearby communities.

**Trainers' views on training of trainers:** Most of the trainers interviewed agreed the TOT was very detailed and improved and updated their knowledge and skills related to LARC service delivery, even though many had previously been trained in this area. However, a few FGD discussants thought that content on healthy timing and spacing of pregnancy and male involvement was a significant gap in the TOT and should have been part of the training.

“I think that there should be a program for male involvement. The problem we need to tackle is really the men because, even after all your counselling and every other thing, the men still resist FP strongly.”

—TOT participant, South

One of the trainers said that the infection control technique had changed and was better compared to what was used previously. Another trainer noted that the content of the session had improved, but the duration for the training remained the same.

## Training CHEWs in Implant Provision

**CHEW trainee selection:** After successful completion of the TOT, SMOH decided on the following criteria for the selection of CHEW trainees: they must be Community Health Officers (CHOs) or CHEWs (not Junior Community Health Extension Workers); they must present their certificate to practice; and they must have been in service for at least three years. As recommended in the scale-up strategy, training two CHEWs per ward, with a focus on one functional PHC per ward, would train a total of 392 CHEWs from the 196 wards (see Appendix 7). CHEWs were initially selected from SMGL sites and later expanded to include non-SMGL sites. The FP coordinators in the LGAs who are responsible for CHEWs also contributed to the selection process and were expected to provide a list of potential trainees to avoid additional training and retraining of the CHEWs.

**Stepdown training:** The stepdown training was conducted by the State master trainers in batches and funded by E2A/Pathfinder. The first batch of CHEWs (60 total) from 30 SMGL sites were trained from May to December 2017. They then received three supportive supervisory visits in 2017. The next batch (89 out of planned 100) were trained between February and July 2018. In total, 149 CHEWs were trained with Pathfinder support as implant service providers in Cross River State, out of a total of 2322 CHEWs in the state. The vast majority of CHEWs in CRS have yet to be trained in implant provision as well as short-acting FP provision.

**CHEWs' views of the stepdown training:** The majority of the CHEWs noted that the stepdown training on LARC was very useful and improved the quality of FP service delivery, particularly for implants. The training had both a theory-based and practical component but was more focused on acquisition of skills and competency. Most respondents also agreed that compared to the training they received in school, they had more practical exposure.

Some of the areas respondents considered useful included counseling, healthy timing and spacing of pregnancy, the importance of informed decision, determining eligibility using the Medical Eligibility Criteria (MEC) wheel, insertion and removal of implants, documentation/record keeping, managing side effects (the most common being bleeding), sterilization, hand-washing, tests one must request before implant insertion (e.g., pregnancy test), and post-insertion counseling (e.g., use of barrier methods in the first 7 days after insertion). Most respondents noted that the training had improved their counseling skills, documentation, infection/disease control techniques, and updated their knowledge on implants and how they are managed.

“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, as well as how to keep records of my activities because we were taught how to document our activities.”

—CHEW FGD, North

## Training-Related Challenges

**Low training coverage:** Despite efforts by Pathfinder and SMOH to scale up TSTS of implant services in CRS, fewer than 10% of CHEWs in the state have received training on implant provision. This has serious consequences for FP TSTS scale-up efforts in CRS. The number trained using the two CHEWs per ward method, as recommended in the scale-up strategy document, is viewed by some FP supervisors as incapable of meeting the increased demand for implant services in the various wards in their LGA, resulting in some wards being under served. Most implementers also stressed that the stepdown training was not well distributed across the LGAs.

“Imagine an LGA like Bekwarra, that has 56 facilities with more than 80-something communities. You now pick only 4 persons from one little area for the training. The training wasn't widely spread to cover the LGA.”

—FP Supervisor FGD, North

Some trainers opined that the training should expand to involve more CHEWs to avoid the risk of the untrained CHEWs carrying out activities for which they are untrained.

“Stepdown training for CHEWs in the facility is not enough for them, especially LARC. Someone who is watching will want to provide. When we went for supportive supervision, whoever was trained was not there and a client came and wanted an implant, so then this CHEW who had received no formal training took the implant and buried it in the muscle.”

—Trainer/supervisor, CRS

Having such a large pool of untrained CHEWs can result in clients losing confidence in the health workers, leading to underutilization of other health services offered in the facility and loss of clients to facilities with trained personnel. Some of the untrained CHEWs admitted to feeling embarrassed and cheated, and said they resorted to deceiving their clients and carrying out procedures for which they had not received any formal training.

“Other health workers refer clients to me—my name is boldly written on the referral form and I am supposed to be the one to [mark] on the card, but I am not the one to insert. But on several occasions, I have watched my senior, who was trained, and I have inserted for some women. God really helped me.”

—Untrained CHEW FGD, Central

“We need more on-the-job training, I had to remove Implanon on two clients without being trained, based on observation in my former health center.”

—Untrained CHEW FGD, Central

**Selection of CHEWs:** Another point identified by one of the respondents was that the criteria for selecting CHEWs for LARC training should include their FP knowledge. She went on to say that most of the CHEWs who are experiencing challenges with implant provision were deficient in basic FP knowledge, which has affected their performance.

**Certification of CHEWs and trainers:** There is insufficient clarity at all levels concerning certification of CHEWs trained in implant provision. According to Pathfinder reports, the CHEWs were informed that the state is in charge of certifications. The FP coordinator noted that a suitable criterion for certification would be defined, but that competency-based supervision must continue as an essential part of the certification process. However, some CHEWs and trainers reported that they had been promised certificates at the end of the training. When asked about certification of the CHEWs, one policymaker reported that the no trained CHEW in CRS had been certified. The respondent reported that they had tried explaining that the initial criteria proposed by SMOH was unreasonably cumbersome, requiring a trainer to observe ten sessions before the CHEW could be certified, and there was no guidance from the national level.

## Community Mobilization

Community mobilization/demand generation is one of the strategic areas highlighted in the CRS FP TSTS scale-up strategy. Some of the implementers, especially the CHEWs in non-SMGL sites, reported that community mobilization was an area receiving limited support from partners in the state (SMGL supported community mobilization, including referrals for FP and reproductive, maternal, newborn, and child health, in intervention sites). Despite lack of funds, CHEWs reported that they carried out community mobilization and demand generation themselves as part of their duties by going from house to house or by using existing communication structures present in the community, such as town announcers, women leaders, religious leaders, and youth leaders. Some of the CHEWs and FP supervisors noted that the LARC training received by the CHEWs 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 also

went out on market days to provide an integrated FP and basic preventive health care package, including immunization. Furthermore, community mobilization was usually carried out before a supervisory visit to ensure there are enough clients for adequate supervision.

Some CHEWs interviewed conveyed that they were currently enjoying some level of closeness to and respect from community members since receiving the LARC training.

“We are closer to the community—they welcome the services and we live with them. If they have any side effects, they come and meet us. We are always there. The doctors don’t live there in the community. They [clients] bring all their problems to the CHEWs. We are working within our LGA and they are our sisters—they are more at home with the CHEWs and we speak the same language. They are not afraid of us. We have a good relationship with them.”

—CHEW FGD, South

## Community-Related Challenges

**Lack of funding:** Some of the health workers interviewed indicated that poor funding by government affected the conduct of home visits and outreach aimed at mobilizing the community and stimulating a continuous demand for implants. One of the CHEWs reported that she had resorted to using her personal money to conduct outreaches and community mobilization to ensure that community members access health care services in her facility. This had resulted in the CHEWs charging clients for services provided to recover funds even when the service is meant to be free.

“The challenge I used to have is that since there is no financial support in doing this family planning when we want to go for mobilization and home visiting, I will use my own personal money for transportation meanwhile the service is free. So at times when I don’t have money, it used to be very hard for me to conduct mobilization and outreaches.”

—CHEW FGD, Central

**Myths and misconceptions about FP:** All respondents (with the exception of nurses) noted that the training received by CHEWs had helped reduce community-level resistance to FP, but they observed that myths and misconceptions around FP persist in some communities, as well as fear of side effects. Persistent common myths and misconceptions about FP in most LGAs include that it prevents women from having children (FP “spoils” the womb), increases promiscuity among youths and married women, affects women’s breast milk, is a sin against God, and reduces the population.

“The misconceptions and fears are that their children will not have children in the future and they will have ample opportunity to experiment [be promiscuous] and be exposed to HIV.”

—FP Supervisor, Central

“Parents of the clients believe their children will become prostitutes or promiscuous and believe that health workers are prostitutes because they know how to maintain themselves and that is what they are introducing to their children.”

—Untrained CHEW FGD, Central

Some of the reasons given by communities who were strongly opposed to FP were desire for large family/population size and religious opposition to FP. One CHEW reported that she was shamed and made to pay a fine in a community she visited for mobilization and awareness-raising about family planning. Another health worker reported that she was made to remove an implant from a woman who had died based on myths about FP.

“In a community I worked in, a woman I had given an implant to died some years later. It is believed that once she reincarnates, she will be infertile and will never have children and so I was asked to remove the implant before she was buried. I was initially terrified, but summoned courage and removed it.”

—LGA FP manager

**Gender inequality:** Issues related to gender inequalities and unequal gender norms were a significant barrier to accessing FP services for women in some communities, as reported by most respondents in this study. In most of the rural parts of CRS, men are the decision makers in the homes, so most women are dependent on them to provide for their needs and make important decisions regarding their health and that of the family. Some of the respondents (CHEWs and nurses) perceived the husbands as a barrier to women accessing FP. While some husbands/partners were supportive and accepted FP, others were not and thought that allowing women to use FP was giving them a license to be promiscuous. Some of the CHEWs interviewed reported that some husbands escorted their wives to the clinic demanding FP services, while others vehemently opposed FP because they felt it might prevent them from having children and might cause infertility. Some clients accessed FP services without their husbands' consent, leading to conflict in their homes. Some of these women were brought back to the facility by their husband/partner, who demanded health workers remove the implant. Some health workers reported having been afraid that the angry men would physically harm them.

“There is a time [women] came and did the LARC... The following day after they had gone, because I am living there, a client and his wife came to beat me up asking why did I come and fix this thing without telling him [the husband]. I tried to save the situation I told him it was not me and I asked his wife who inserted her she said no that it's a small fine girl and she is not here again.”

—FP Supervisor FGD, Central



“Most of them don’t want to accept it [FP], especially their husbands. Two weeks ago I had a client who came for Jadelle and, after it was inserted, the husband came on Friday and said if I did not remove the Jadelle then she [the client] would move to the clinic and come stay with me, because he wished to continue having children. So I told him that he should allow her to keep it for a year and then she can come and remove it because the woman was currently nursing a baby. If the baby is grown and he is ready for another one, he can bring her to remove it, but he said no, I should remove it.”

—Nurse FGD, South

In addition, some of the CHEWs observed that, because of the implant’s longer period of efficacy and the quick return of fertility, some women perceive it as a form of liberation from the risk of maternal death. The introduction of implants gave birth to the name “*odeshi*” (my power), as women named their newfound ability to space births and exert control over their bodies, and many men in these communities felt threatened by it. This has resulted in husbands who do not support FP checking their wives’ arms daily to verify that they had not gotten an implant without their knowledge.

## Supervision

Supportive supervisory visits for CHEWs trained to provide implants were carried out by the state, with financial and technical support from Pathfinder, using a monitoring checklist. Before supervisory visits, extensive community mobilization was conducted by health workers using relevant communication channels within their communities to ensure that adequate number of clients were available for observation. As suggested in the FP scale-up plan, the supervisions were planned for each month.

During supervision, the supervisor/trainer observes the following: preparation of equipment and insertion room, the processes followed for group and one-on-one counselling, clinical examination, the insertion procedure, documentation, waste disposal, and adherence to standard operating procedures. Errors identified during supervision (e.g., poor insertion techniques, poor counseling techniques, non-adherence to infection control procedures, and poor documentation) are corrected and additional training and mentoring are provided for the CHEWs who still have difficulty with implant insertion.

## Supervision-Related Challenges

**Frequency of visits:** Supportive supervisory visits for CHEWs trained to provide implants was led by the state with financial and technical support from Pathfinder. Many respondents (policymakers, implementers, trainers, and FP supervisors) reported that the trained CHEWs required additional training and needed to be closely monitored with more frequent supportive supervision to ensure that quality of care is maintained. One of the state trainers/supervisors stressed that strict monitoring and ongoing/recurring supervision is key.

“I think what they really need is constant supportive supervision because at times you get to a particular facility that you had supervised and find they are doing the opposite again. It means we have to constantly supervise and monitor, which is what we are doing every month.”

—State Trainer, CRS

Most implementers, including policymakers, felt that the supervision and mentoring provided were inadequate or unevenly distributed, favoring some LGAs more than others. Although the FP TSTS scale-up strategy recommends monthly supervision of CHEWs, most CHEWs trained in January 2018 indicated that they had received as few as three supportive supervisory visits and a few had not received any supportive supervision at all since being trained.

One respondent suggested that infrequent supervision was since, in the beginning of the year, all supervisors were conducting trainings for more than 100 CHEWs, making it impossible to conduct supervisory visits at the same time.

**Lack of broad stakeholder buy-in and support:** Poor funding by the state, inadequate staffing, and overdependence on development partners to support supervision were identified as potential causes of the poor supervision. Another reason was that the centrally located supervisors, most of whom live in Calabar, were often unable to travel to supervise the CHEWs scattered throughout the state. Most respondents advocated for monthly supervision to ensure that quality of care is not compromised. In late 2018, Pathfinder increased supervision from quarterly to monthly as a result of some of the reports from the field.

“There is a serious concern and that is why we are now carrying out joint monthly supervision because of what we have seen. You know, you’ve trained a CHEW and on the first visit—maybe because you were there monitoring—the person tries to follow the established rules. But on another visit, you won’t believe it’s the same person who had tried to do the correct things. Because it is something they have not done before and they are used to taking shortcuts when you are not there, so they want to try that shortcut. It is our place to bring them back to following the right way and master it, because there is no shortcut in this thing—the shortcut might cause problems and the quality of care might be compromised.”

—Development partner, CRS)

## Commodity Security

The federal government, with support from UNFPA, leads procurement and supply of FP commodities in Nigeria. The commodities supplied to each zone are calculated based on the quantity procured for the country and supplied to the different zonal stores. FP commodities are then distributed by a third-party logistics company, Chemonics, directly to the various facilities based on requisition using the Integrated Last Mile Distribution (ILMD) method, which is currently being piloted in CRS. Prior to implementation of ILMD, the state supplied commodities to facilities via the bimonthly review and resupply meetings. ILMD involves a physical flow of products to the point where end users can access them. These commodities are usually delivered without accompanying consumables. Consumables were provided through partners to Pathfinder-supported and some Marie Stopes-supported sites, but other health facilities were forced to procure their

own consumables. Some of the affected facilities either borrowed from neighboring facilities or resorted to charging clients a token fee for consumables.

## Commodities-Related Challenges

**Uneven commodity distribution and stockouts:** The respondents identified challenges with inadequate commodity supply to meet the increasing demands for FP. Most respondents identified FP commodity stockout as a barrier to effective implementation of the FP TSTS scale-up efforts in the state. Stockouts affected implant service delivery in the state and led to loss of clients. The lack of commodities also meant that CHEWs were often unable to perform insertions when supervisors were visiting, making adequate supervision of CHEWs' insertion abilities difficult.

**“I really need the commodities—I already have 4 people waiting for the service so I may have to borrow from another facility and give them the data or risk losing that client and never be able to track her down again.”**

—CHEW FGD, Central

Some stakeholders interviewed reported that FP commodities were unevenly distributed among health facilities in their LGAs and linked this to challenges in supply chain, while others attributed it to the ILMD method. The majority of stakeholders reported that commodity stockouts were a recent development that began when the federal government, in collaboration with UNFPA, took over supply and distribution of FP commodities. A program officer from the Ministry of Health explained that when FP commodities were controlled at state level, stockouts were not as frequent. The respondent attributed the increase in stockouts to the selection of the state store as a zonal hub for the South-South geographical zone of the country, with partners now responsible for distribution with little to no input from the FP Supervisors in the LGA.

**“Before, when the state was in control of commodities, we didn't have problems—until they made our warehouse a zonal hub. They bring commodities and stocks for the six states and each state comes and picks up its own and leaves, so we really don't have commodities on hand like we used to before. Before, they would ship our own [commodities] to us, we would receive it, and keep it in the warehouse. Then we would do a review and distribute to all facilities. But this time around it is not so and, as we speak, there is a serious commodity stockout.”**

—Program Officer, SMOH

Additionally, the limited involvement of the CRS Family Planning Unit in the supply and distribution of commodities may have also contributed to these shortages, as was highlighted by one of the respondents:

“Commodities are now being distributed through a zonal store in Calabar. So now the Family Planning Unit does not know anything about commodities. So, the people distributing the implant commodities go straight to the facility. However, when they distribute, they are only distributing what they have, it might not even be what you need or what is required in the facility. Since then, we don’t even have access to commodities and so we have a lot of problems with logistics.”

—State Trainer, CRS

*Inadequate supply of consumables:* In addition to the implant commodities shortages, most respondents noted that the supply of consumables was a major challenge experienced by health facilities offering implant services. A stakeholder in the FP Department reported that most FP commodities are not supplied with consumables and that this was a major bottleneck for implant service provision in CRS. The consumables are currently supplied by the state and many health workers noted that, even when commodities are available, the consumables are not. Some of the respondents reported that this situation has resulted in health workers procuring these consumables themselves without waiting for the state and charging the clients a fee for the consumables. However, some respondents reported that some health workers are taking advantage of this situation to make money and extort exorbitant fees from the clients. This has led to loss of clients, who had been told that services were free of charge, and may affect the quality of care given to FP clients.

“Another issue is bringing the commodities without bringing the consumables. So, you put pressure on the facility. They resort to under the table charges to make money to run the services. If you manage to convince someone to accept and then you ask her to pay, she will just run away.”

—Health Officer, CRS FP Department

In an effort to address the problem of chronic shortage of consumables in the state, Pathfinder provided some funding for consumables, but this did not deter the health workers from charging the clients for implant services.

“Some facilities were charging up to 1,000 naira and Pathfinder is saying ‘No, this service is free.’ And they tell us that commodities are free, but the consumables are not there, and we are saying ‘Must you charge up to 1,000 naira per client to get the money for consumables? Please can it be lower?’ So, we have also tried to provide a little of the consumables, but after Pathfinder leaves what happens? They might go back to collecting more money.”

—Development partner, CRS

## Stakeholders’ Views on the TSTS Policy

### Policymakers’ Views on FP TSTS

Many of the policymakers surveyed were initially skeptical about the policy because they felt the CHEWs did not have the requisite foundational knowledge and training to take on the tasks being shifted to them. However, as the training and supervision were rolled out, some of trainers began to appreciate the need for

the TSTS policy. The majority of trainers/supervisors and policymakers ultimately embraced the TSTS policy and saw it as a necessary stopgap mechanism to address the chronic shortage of health workers in the state resulting from a freeze on employment of nurses and dearth of health professionals. Some policymakers stated that strict supervision and monitoring are required to maintain the quality of care, particularly with respect to infection control.

“I think it is very important and appropriate at this time—a time when we have a dearth of health care workers. We have very few doctors and nurses in the state right now. Many of them have moved to the Federal Teaching Hospitals. 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 because we don’t have doctors and nurses. So, I just think it is the best we can do considering the circumstances we find ourselves in.”

—Health policymaker, SMOH

“I was initially skeptical because I know the people we wanted to task-shift to. My worries then were about how these people would manage, with the level of their understanding and education, to provide quality care as far as FP is concerned—and what were we handing to the public? But I think I was wrong because when they started building their capacity I could see that some of them could actually pick it up fast and that they are doing it.”

—Policymaker/trainer, SMOH

Some policymakers, however, vehemently opposed the implementation of the TSTS policy because they felt that nurses were graduating from the colleges but were not being employed, in favor of less-expensive CHEWs, and they were not confident about the CHEWs taking on these tasks. In addition, one of the policymakers mentioned that, on top of the nurses’ unions resisting the TSTS policy, many fear that the nursing profession is heading towards extinction and the TSTS was seen as a threat to their profession.

“We keep talking about task-shifting because there is supposed to be what I call ‘imaginary’ lack of personnel [nurses and doctors] in particular areas, whereas they are there on the streets. They have graduated and are there, unemployed, and you are now talking of task-shifting and taking another person’s job and giving to other less qualified persons. I will not subscribe to that even though I have been carried along. So, if you ask my candid opinion, I would tell you emphatically that ‘I don’t want it—I don’t like it’. It’s not going to solve the problem we are facing, as far as the health crises in Cross River and Nigeria are concerned. Let there be square pegs in square holes.”

—Policymaker, training institution

### Nurses’ Views on FP TSTS

Some of the nurses interviewed felt that the TSTS policy had some benefits following the training of the CHEWs on implant service provision. One of the FP supervisors and several nurses in the LGA reported that with the CHEW training had freed up some time for the nurses to do other more technical tasks in the facility, such as IUD insertions.

“With this task-shifting, the workload on nurses have reduced drastically and it’s working very well.”

—FP Supervisor FGD, Central

Of the nurses interviewed, some felt threatened by the TSTS policy, while others believed that TSTS had some advantages and that tasks could be shared with CHEWs due to the shortage of nurses in the LGAs. Their main concerns were that some of the CHEWs who had been in service longer than the nurses and in charge of these facilities did not allow nurses to perform their tasks optimally and were not willing to take feedback from the nurses. Some of the respondents further perceived that the CHEWs were threatened by the presence of nurses in their facilities and tried to make them irrelevant in the facilities.

“I don’t really support this policy because, in my facility, I only go there, sign the timesheet, and sit down. I don’t perform any duties, even in the ANC and FP units, except maybe if I’m on night duty. But if I am on morning duty, I only sign the timesheet and sit there, because the CHEW won’t even let you do anything. I only work when they are not around.”

—Nurse FGD, South

“To some extent, there is an advantage of this policy in that activities could be shared amongst each and every one of us, be they a nurse or a CHEW. But the only problem I have is the way they do it and when you try to correct them, they are not willing to take correction, especially if you are a nurse. I don’t know why.”

—Nurse FGD, South

“This conflict will be a serious barrier. For instance, I am a nurse and I have my job description, and then a CHEW is right there struggling with me to do my job in the presence of the client. What if the client begins to doubt our competence and, at the end of the day I lose the confidence of the client, and the client goes?”

—Nurse FGD, South

“It is a conflict because, when the CHEWs see the nurses, they say ‘These white people’<sup>b</sup>—they call them white people—‘have come again.’ We even had a case in a facility, where I had to go to the DG of PHCDA in the state, because my student nurses went for community posting and were sent away by the CHEWs, who told them that their place was in the secondary health facility, and they had no business here.”

—State Trainer

The CHEWs interviewed expressed varied views about friction with other health professionals. A few CHEWs with nurses in their facilities claimed that they enjoyed a good working relationship with them. Others stressed that friction persists between the CHEWs and nurses in particular. One CHEW was of the view that the nurses and doctors looked down on them, making them feel inferior to other health professionals, and went as far as locking up commodities and preventing CHEWs from observing them perform technical procedures.

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<sup>b</sup> By “white people,” the CHEWs were referring to the white uniforms or coats worn by nurses and doctors, not the color of their skin.

“The relationship between the CHEWs and nurses poses a lot of barriers to service delivery. The idea is that the system is a team and, in the team, even the laborer, the driver, is a member of the team. But oftentimes we are looked upon as inferior in this system. It is a very big barrier. The midwives most times won’t even give you the opportunity to see what they are doing and the relationship between the CHEWs and nurses was not so good. We were looked down on, but thank God for the training that has empowered us a bit.”

—CHEW FGD, North

### Stakeholders’ View of the Resource Team

The process of developing and implementing a scale-up strategy through the RT resulted in several achievements and revealed several challenges. In FGDs and KIs, respondents highlighted the adoption of the scale-up strategic document by the State Council of Health and expansion of the RT’s mandate to support scale-up of other health interventions beyond FP as key achievements. There was also a widespread perception that the resource team supported the CRS government to take ownership and leadership of scale-up, helping advance the process of institutionalizing the innovation. Additionally, respondents believed that the RT generated awareness of the benefits of task-shifting provision of implants and identified stakeholders to support FP task-shifting scale-up efforts through advocacy visits.

A major challenge to the implementation of the scale-up strategy was the perception that the scale-up effort (including the RT itself) was a Pathfinder initiative. Although the Commissioner for Health wrote a communiqué mandating that partners in the state support the process, the response was extremely slow. Additionally, several RT members demonstrated a lack of commitment, rarely attending meetings or sending several representatives who have little to contribute to these meetings. According to a member of the RT, the meetings were not held from July 2018 through December 2018 due to poor attendance. This member perceived that other RT members viewed it as a Pathfinder initiative, as opposed to a stat initiative, which indicates that there were problems in securing local buy-in and ownership. Finally, funding constraints have limited scale-up, despite the efforts of the RT to ensure that funding is made available to expand access to implant service provision.

“Funding has been an issue, apart from salary of people we pay; in terms of service funding, it has been very weak. What we have done/try to do is to support the ministry to do what is required for funding to be available.”

—Member Resource Team, CRS

# IMPACT OF TASK-SHIFTING, TASK-SHARING ON FAMILY PLANNING SERVICE DELIVERY AND USE

## Patterns of FP Service Use

### Increased Uptake of Contraceptive Implants

During discussions and interviews with CHEWs, FP managers, and community members, most respondents expressed that they had observed an increased acceptance of and uptake of family planning methods (especially implants) in most LGAs. This finding was corroborated by service statistics presented in Figure 1, which demonstrates an increasing utilization pattern for implants compared with other FP methods (injectables and IUDs). This coincides with the period CHEWs were trained to provide implants (Q3 2017 to Q3 2018). The distribution of commodities by CHEW-led and non-CHEW-led facilities, as seen in Figure 2, shows that the majority of implants were provided by CHEWs. Additionally, IUD uptake increased slightly, with uptake being highest in Q2-Q3 2018. It is possible that, with more implant insertion being performed by CHEWs, nurses were freed up to perform IUD insertions, as suggested by some respondents.

Figure 1: Trends in the Number of LARC Users in all LGAs of CRS by Method in 2017 and the First Three Quarters of 2018

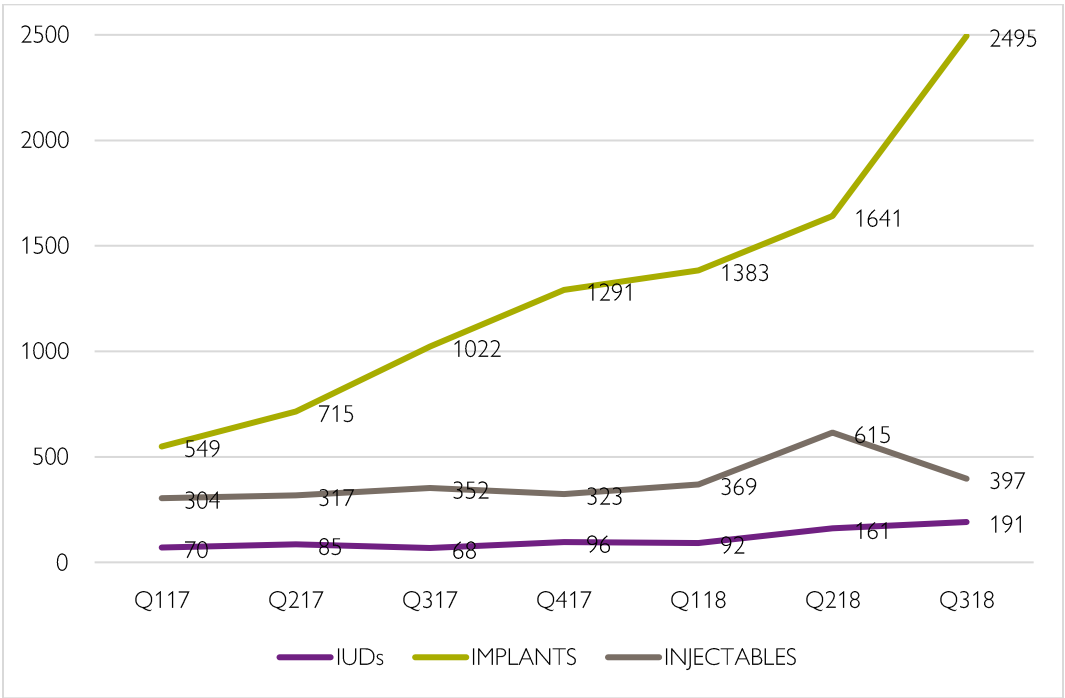
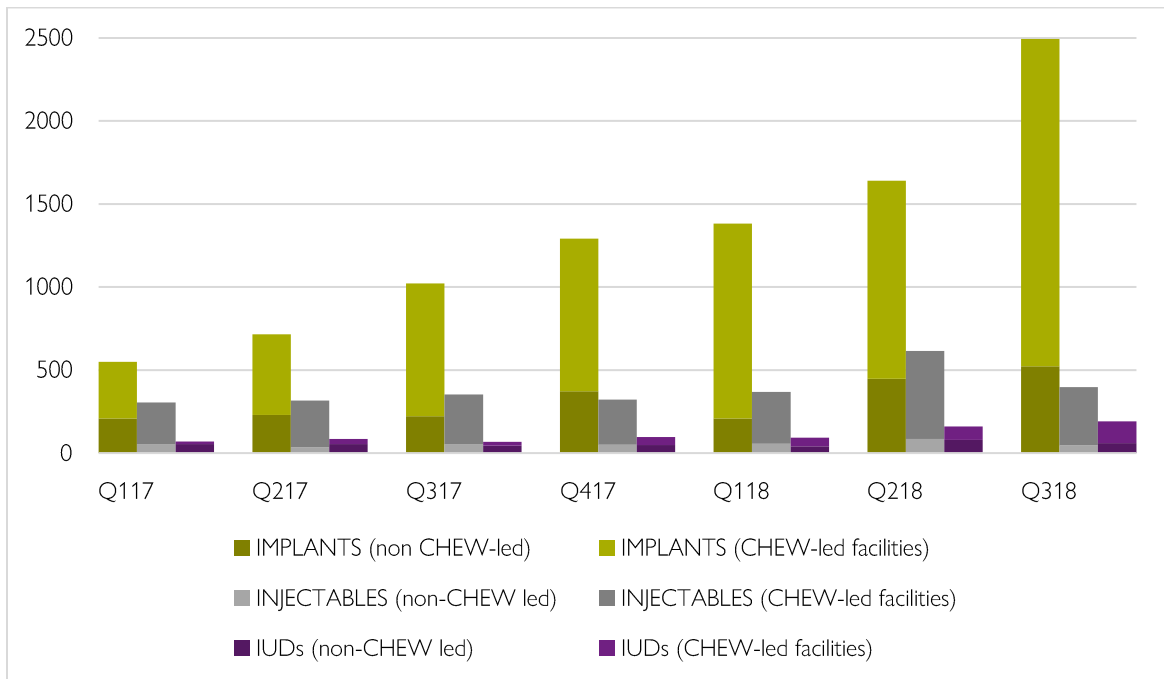




Figure 2: Trends in the Number of LARC Users in all LGAs of CRS, by Method and by Distribution at CHEW-led or non-CHEW-led Facilities, in 2017 and the First Three Quarters of 2018



Many discussants reported that they observed an increase in women of reproductive age in their communities independently seeking FP services, which they said was rare in the past. They felt that this was linked to: greater awareness of FP in the communities; the fact that many commonly held misconceptions about FP had been corrected by CHEWs and other service providers, who provided adequate information regarding FP; improved FP counseling skills among CHEWs; and improved communication about the advantages associated with implant use (e.g., longer duration of efficacy than injectables, leading to lower transportation costs; minimal side effects; and near-immediate return of fertility following implant removal). This may explain why the uptake of injectables is on the decline particularly in the third quarter, as observed in Figure 1 above. The CHEWs also reported that expanding their roles to include implant provision has also led to perceived increased availability and accessibility of implants by community members. Implant use increasing from 59.5% in first quarter of 2017 to 80.9% in the third quarter of 2018.

Many of the CHEWs reported that many women in their communities opted for the implant because the method allowed them to space their children and prevent unwanted pregnancies, thus allowing women time to take care of their children and to continue their education and other pursuits.

**“Those [clients] who need FP just walk freely into the facility and get it, and are happy about it. The rate of abortion has reduced drastically.”**

—CHEW FGD, Central

“The LARC training has really done a great thing in the community in the sense that, before when a client came asking for Implanon/Jadelle, because CHEWs could not provide the service, we would ask the client to leave or we would offer them [methods] that were available. So the client wouldn’t receive the [method] she really needs. But with the LARC training we received, clients keep coming because they are confident that any time they come someone will attend to them.”

—CHEW FGD, Central

### Increased use of PHC Facilities

The LARC training received by CHEWs was perceived as increasing clients’ use of the PHCs, which were previously underutilized. Respondents also viewed task-shifting/sharing as having improved many communities’ confidence in the CHEWs’ ability to deliver health services: some CHEWs observed that the addition of implants to the package of services provided by CHEWs had increased community members’ use of other health services provided at this level of care (e.g., antenatal care, treatment of minor ailments, immunization, and delivery services).

One of the trainers indicated that, in the past clients, were referred to nurses in secondary facilities if they needed implant services, but that this has since changed.

“I am satisfied that people no longer run to the secondary health facility for this service. Whether the CHEWs are doing it right or wrong, but I know that it is no longer as wrong because now they have a fair knowledge and skill in what they are doing. So, it has actually reduced the crowding in secondary health facilities—making the services more accessible at the community level.”

—State Trainer

“People in the community are now coming very close to the services [accessing services], and they know too that it is not only about the nurses in these facilities, but the CHEWs too.”

—CHEW FGD, South

In addition, FP services are readily available and provided daily based on client demand (rather than a set day or time to provide implants). The CHEWs reported that some clients prefer to come for FP services in the evenings if they need more privacy or are busy during the day as implant services can be accessed at any time.

Some CHEWs perceived that the provision of services to young and adolescent girls, working in conjunction with SMGL youth-focused services such as the First Time Parents project,<sup>15</sup> led to a reduction in unwanted teenage pregnancies and unsafe abortions. Some of the CHEWs reported that before young girls could not freely access FP services because they would be labeled as promiscuous. But with increased sensitization and awareness given to the communities, more young girls came to clinics demanding implants.

“Now when you can see a young girl coming to the facility who wants to use family planning, and you ask her ‘Why do you want it?’, she says, ‘Ah mama, I am in school oh—I want to finish my school.’ So, you know it is working well.”

—FP Supervisor FGD, Central

On the other hand, most of the untrained CHEWs mentioned that increased awareness and subsequent demand for implant services among community members had some drawbacks. In some facilities, health workers stressed that FP commodities were being exhausted rapidly, leading to frequent commodity stockouts. With just a handful of trained health workers to meet this increased demand for LARCs, some of the untrained CHEWs admitted losing clients to other health facilities with trained personnel. They perceived that this resulted in many clients losing confidence in them.

“Clients lose confidence in untrained health workers who will in turn lose their clients. With the increase in demand for LARC services, the number of CHEWs trained is still very small.”

—CHEW FGD, North

## Concerns About Service Quality

### Lack of Space and Privacy for FP Services

Most respondents thought that ensuring space to provide FP services in most PHCs was a challenge to effective implant service delivery. Privacy and confidentiality are important elements of quality FP service delivery and, if absent, may discourage clients from using the service. CHEWs interviewed admitted that there was no separate room designated for FP services and they had to make do with what was available in their facilities, which often was not ideal. While some health workers reported trying to make space for FP service delivery in their facilities, many reported that clients either came for FP services in the evening after other health service users have left the facility or did not access the service at all.

“I think space is also a barrier. When you are talking about the family planning unit, you look at the waiting room which will be as big as this room and then you have the insertion and the counselling unit. Most of the time, you see there is a very small room that is serving as a counseling unit and insertion unit, so if you are going for family planning services there is no privacy and confidentiality like you would at a teaching hospital. They have a very big place, but when you now move over to the other facilities, the space is not there.”

—State Master Trainer

### Untrained or Inadequately Trained CHEWs

The majority of the trainers/supervisors and a few policymakers expressed concern about the CHEWs' capacity to successfully provide implants. While some CHEWs gained the required skills and competencies and successfully provided implants, reports from supervisory visits indicate that others were deemed incapable and/or untrainable. One supervisor admitted that just a handful of trained CHEWs were competent and able to do what they had been trained to do. Moreover, some trainers/supervisors and some

of the CHEWs admitted that many CHEWs had difficulty removing implants and there were some cases of lost implants and botched removals. This was attributed to very deep insertions carried out by some of the newly trained or untrained CHEWs.

“For the people that had implants inserted some time ago, when they come [for removal], the thing will be too deep. You will have to struggle for hours to remove it.”

—CHEW FGD, Central

Several policymakers and nurses expressed concerns about untrained CHEWs providing LARCs. Some of the nurses reported that in CHEW-led health facilities, they had observed CHEWs performing tasks that they were not trained to do (e.g., IUD insertion).

“My madam was not trained on IUD [provision], but since I have been posted there, she has always been carrying out the procedure. When you look at it the aseptic technique is not there. I see other CHEWs coming to watch what she is doing, but I always tell them that what she is doing is not right and that there are some things she is doing wrong, so they shouldn’t learn from what they are seeing her do. My madam is a CHEW, so if you are talking about us carrying out other highly technical things, they want to do everything. The only time you [nurses] do anything is when they are not there.”

—Nurse FGD, South

Some of the nurses interviewed also expressed concerns that CHEWs were more interested in the money they would make from the clients/patients, rather than offering quality services.

## FACTORS AFFECTING SUSTAINABILITY AND SCALE-UP

### Facilitators and Barriers to Scale-up

The preceding sections have presented results from the study highlighting both factors that facilitated and challenges that hindered scale-up of the task-shifting/sharing of implant provision. These factors were identified based on respondents’ perceptions of the scale-up experience. Tables 3 and 4 summarize these barriers and facilitators and indicate the cadre of worker that identified each one.

Table 3: Facilitators of Scaling up the TSTS Policy

Facilitators	Policymakers	CHEWs	Trainers	LGA FP Supervisors	Nurses	Resource Team
Training	++	++	++	++	–	++
Acceptability and uptake of implants	+	++	++	+	–	+
Improved relationship of CHEWs with community members	–	++	–	++	–	–
Creating more time for other activities (for nurses)	–	–	–	+	++	–

**Key:**

++ = opinion expressed by most of the respondents

+ = opinion expressed by some of the respondents

– = opinion not expressed at all

Table 4: Health System and Community-Based Barriers to FP TSTS Scale-Up Efforts in CRS

Barriers	Policy-makers	Implementers	Trainers	LGA FP Supervisors	Nurses
<b>Health system</b>					
Stockouts of commodities/ consumables	+	++	+	++	++
Shortage of trained personnel	++	++	+	++	+
Lack of space to provide FP services	–	++	–	+	–
Poor funding of FP in the state	++	+	+	+	+
Concerns about sustainability of the FP TSTS efforts	++	+	++	++	++
Training gaps	++	++	+	+	++
Concerns regarding the TSTS	++	–	++	++	++
Misconceptions and myths about FP	+	+	+	+	+
Inter-professional conflict (CHEWs vs nurses)	–	+	+	–	++
Hidden charges for implant services	++	–	+	+	++
Gender inequity and harmful social norms	–	++	+	++	+

**Key:**

- ++ = opinion expressed by most of the respondents
- + = opinion expressed by some of the respondents
- = opinion not expressed at all

**Concerns About Sustainability**

Issues concerning sustainability of TSTS of implant services was a significant barrier to the scale-up efforts in the state. Many of the respondents, particularly policymakers, expressed fears about the program’s sustainability. Many feared that weak political will and the government’s unwillingness to take ownership of the program after the end of SMGL in mid-2019 would be a challenge to the FP TSTS scale-up efforts. Some of the respondents suggested that another partner should take over from Pathfinder after they leave CRS.

“Then the challenge you will see it more when Pathfinder pulls out. The government is not interested in assisting as far as health is concerned, not to mention FP. So, all that the partners have been helping us to do—paying their transport maybe for cluster meetings and all the other things they have been doing—all those things when partners go... Well, let us not say we don’t have anyone because we don’t know whether another partner will come, but for now the picture we are seeing is that we will not have anybody to assist us implement.”

—Policymaker, SMOH CRS

Another reason for this concern was the consistent lack of government commitment and poor funding of FP-related programs by the government over the years. Policymakers stressed that most achievements in FP service delivery had been with the support of partners. Government overdependence on partner support has been termed the reason for this lack of commitment towards health programming. One policymaker noted that, even when the government has the will to execute a program, the funding is usually a major obstacle.

“The greatest challenge in the health industry has been funding. Because partners come with the financing, we work well with them. We are just adding a little like counterparts. When they leave everything for us, we may not have adequate funds, despite having the will to do it.”

—Policymaker, SMOH CRS

As noted by most policymakers interviewed, even where there is a budget line for FP, funds are rarely released. The paucity of funding has contributed to lack of consumables in many facilities; exorbitant or unnecessary charges to clients accessing these services; reduced demand for implants, if outreach services aimed at generating demand are not conducted regularly; poor quality of care; inadequate supervision of CHEWs; and overdependence on partners' support.

“Even before SMGL came, in fact even before Pathfinder started taking activities deep in FP and other things, family planning had a budget line in the State Ministry of Health budget. The first budget that was approved was 10 million. Not one naira was released. The following year they cut it down to 5 million. Nothing was released. It's not that we don't apply for the funds—we apply, but nothing is released and, even as we speak, not a kobo has ever come from the government. So, there hasn't been any support from the state.”

—Policymaker, FP Unit

Another policymaker tried to explain that most of the items captured in their budget were implemented at the national level, so funds disbursed to the states are usually diverted to meet other pressing needs, particularly if development partners indicate an interest in supporting the health intervention.

“Most of the things which we budget for are being done at the federal level, apart from the trainings. So sometimes when you look at the pressing needs, we divert the money to those pressing things. At least this one has support from other places.”

—Policymaker, SMOH

Program officers also expressed concern that most of the achievements associated with the LARC training and task-shifting may be reversed if partners withdraw their support. One policymaker noted that if the government does not provide FP commodities free of charge to clients, as is currently the case, it may result in reduced demand for the service. If funds are not made available for supervision of CHEWs, then most of them will do as they like and there is fear that the untrained CHEWs will perform tasks that they are not trained to provide.

“If one day the government rises up and says ‘I can no longer supply commodities for free,’ it is most likely that the people will not be able to buy them, because even now that they are providing this LARC, we give them for free ... and sometimes provide the consumables. What will happen when all of these are not there?”

—Policymaker, SMOH

“Well, Pathfinder in their project, they are ending. They have a few months, if you count because September is here. A few months and they will be rounding off. If those key partners who have been supporting these processes are no longer there, we may likely fall back to what it was or we may just give the providers—whether CHEWs or nurses, whoever they are—the full power to operate the way they wish. We won’t even have the guts to supervise or want to reprimand and do anything to anybody.”

—Policymaker, SMOH

Most trainers believed government should commit some funding to implant service provision if sustainability is to be attained. One trainer also noted that SOML has an FP component, which is an opportunity to train more CHEWs and pick up where Pathfinder leaves off, but the release of these funds remains a challenge. Another trainer suggested expanding training to include all nurse tutors, hospital tutors, and tutors from colleges of health technologies so that CHEWs receive LARC training while in school, not after they graduate. This was a major component of the FP TSTS scale-up strategy that has not yet been accomplished.

“There is no sign of commitment from the government from any angle and, if nothing is done, as soon as the partners go, the whole thing will collapse because now we want to do LARC training using SOML funds, but it’s taking them time to release this money. It’s not as if the money is not there and we know that family planning is one of the pillars of SOML, so why are they not releasing this money? So, if there is anything that can make the government release this money, and it is possible for the state, we can afford it.”

—State Trainer, CRS

Poor funding of FP services also affected the resource team’s capacity to function optimally in supporting FP (implants) provision. A member of the resource team noted that a weak funding mechanism will negatively affect the CRS scale-up efforts, especially if the resource team is non-functional. He stressed that without a firm funding arrangement the resource team is handicapped particularly in the areas of advocacy, monitoring and supervision. The resource team member further pointed to the fact that the presence of political support and commitment could result in release of funds and vice versa.

“The number one problem is money because I want to work, but I have not been able to because I am still trying to look for who will support, but until we get a firm funding arrangement it will remain. I also think that if political will is present, it will bring funding and if funds are in place, I think most of the issues can be dealt with.”

—Resource Team member



# CONCLUSIONS AND RECOMMENDATIONS

## Conclusions

The expansion of the roles of CHEWs to include implants in their service provision is a necessary and timely intervention to address unmet need for FP in CRS. With support from E2A and Pathfinder Nigeria, CRS successfully began to implement the FP TSTS scale-up efforts in the state using a systematic scale-up strategic plan. These efforts have led to:

- Increased uptake of and demand for contraceptive implant services, including in communities previously resistant to FP
- Enhanced technical/clinical capacities among CHEWs
- Improved relationships between CHEWs and their communities
- Additional time for other health workers (namely, nurses) to focus on more technical duties (e.g., IUD services)

However, certain barriers have been identified as possible threats to the FP TSTS scale-up efforts, including the following:

- Limited training coverage (less than 10% of CHEWs have been trained in implant provision)
- Inadequate supervisory support for CHEWs
- Commodity insecurity
- Weak funding for FP
- Inter-professional conflict between nurses and CHEWs
- Gender issues
- Persistent myths and misconceptions about FP
- Concerns about the sustainability of the FP TSTS scale-up

The issue of sustainability remains an area of concern for most respondents due to overdependence on partners by states with poorly funded health budgets. Scale-up efforts need considerable amounts of funding to implement activities and health systems need to be strengthened if sustainability is to be maintained. If existing systems are weak, or if key systematic components are absent, there is in effect no system into which to integrate. Strengthening of the health system is key if scale-up (vertical and horizontal expansion) is to occur smoothly, including in the areas of advocacy, capacity building, logistics and procurement, and M&E. Additionally, demand creation is crucial to scale-up but does not receive as much attention as other components. Monitoring and supervision of CHEWs, which is cost intensive and centrally coordinated, may not be sustainable in the long run if partners withdraw support and the government is to sustain the health innovation. It is therefore important to have a diverse range of user organization partners to provide and leverage resources to support the expansion of FP TSTS. With the end of the SMGL initiative in late 2019, the state needs to reconsider its own role in leading this effort, as well as identify partners to support certain components through their workplans.

## Recommendations

In light of the promising results presented in this report, as well as the risks posed by the above threats to success and sustainability, it is crucial that the barriers to the successful scale-up of this innovation be addressed.

Respondent recommendations were identified and are presented in Table 5, by the cadre of worker that recommended the action.

Table 5: Recommendations from Study Respondents

Recommendation	CHEWs	Trainers	Policy-makers	Partners	Nurses	FP Supervisors
Expand training to include more CHEWs	Green	Green	Green	Green	Green	Green
Strengthen supervision and M&E	Green	Green	Green	Green	Green	Green
Involvement of other partners and government	Green	Green	Green	Green	Green	Green
Ensure a steady supply of commodities and consumables	Green	Green	Green	Green	Green	Green
Improve funding for FP	Green	Green	Green	Green	Purple	Green
Improve demand generation targeting hard-to-reach communities by the state	Green	Green	Purple	Purple	Purple	Green
Improve male involvement	Green	Green	Purple	Purple	Purple	Green

Green = Recommended

Purple = Not Recommended

Based on the collected data, E2A recommends the following actions:

### 1. Reconfigure Resource Team

The RT is a major player contributing to the success of scale-up efforts and thus it needs to be funded and supported. One of the challenges faced by the RT is lack of commitment of members. The RT is largely viewed as a Pathfinder initiative due to the composition of the RT and centralization of power in the chairs, who were closely associated with Pathfinder. The RT needs to be reconfigured, at the direction of the state,

to be viewed as a government-led entity and non-committed members should be removed and key players identified who will support the scale-up process through lobbying and advocacy. The resource team should also increase advocacy visits to relevant stakeholders and key players to ensure that funds are released to ensure sustainability of the FP TSTS scale-up efforts. The resource team could also work with professional bodies to address inter-professional conflict between nurses and CHEWs. Finally, there is a need for a constant and even distribution of commodities and consumables to meet increased demand for FP. This must include a written, agreed-upon plan and government funding to ensure continuous delivery of FP services at the state level.

## 2. Adopt a Decentralized, LGA-based Training Approach

Adopting an LGA-based stepdown training approach supervised by the state is the most promising way forward and could be more sustainable than a state-based approach. In LGAs where there is a Pathfinder-trained master trainer, Pathfinder should begin by supporting a planning process at the LGA level, that is focused on an LGA-based stepdown training. With a new decentralized LGA-based training model, it will not only have greater impact in terms of the number of CHEWs who can be trained in the coming year, but will also be more cost-efficient and build sustainability within the system for further expansion of CHEW training. This sets the stage for statewide implementation of scale-up in terms of coverage of CHEWs who can provide LARCs, allowing more women to access LARCs where CHEWs are the only providers. Other recommendations include expanding trainings to more CHEWs to avoid the issue of untrained CHEWs carrying out activities that they are not trained for, selecting CHEWs based on clearly defined and published criteria, and training and retraining CHEWs with particular attention on removal of implants. The certification of CHEWs also needs to be reassessed at the state level: the certification currently depends on rigorous supervision at ten different occasions of implant insertion, which is often logistically impossible.

## 3. Ensure Quality Control

A strong monitoring system and plan should be put in place to prevent, respond to, and mitigate unexpected negative consequences. Once the capacities of the CHEWs are built, they should be followed up by frequent monitoring and supervision to ensure that quality standards are maintained. FP supervisors who are eligible can also be trained to supervise CHEWs at the LGAs and will not just be responsible for commodities. In addition, a peer-to-peer monitoring system, as recommended in the scale-up strategy, may be useful. During supervisory visits, CHEWs who are found to be competent could monitor CHEWs who are still finding the procedure challenging.

## 4. Explore Governmental Funding Sources

Government projects, such as the Saving One Million Lives (SOML) project, have the ability to fund implant scale-up, thereby increasing government ownership and fiscal involvement and reducing dependence on partners. SOML has an FP component, which is an opportunity to train more CHEWs and continue scaling-up TSTS of implant services in a more sustainable manner.

## 5. Drive Demand Generation

As noted above, increasing the impact of task-shifting depends on reaching more women. It is necessary to improve demand generation activities, particularly to increase male engagement and in hard-to-reach communities, through community-based communication interventions targeted at men to improve acceptance of FP. Harmful gender norms also contribute to low demand and use for LARCs, as has been seen in numerous FP programs, and gender inequity needs to be addressed along with other demand generation interventions.

Scaling up task-shifting FP to CHEWs requires strong political and resource support for institutionalization within state systems. By working with the facilitators and 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.

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## APPENDICES

### Appendix 1: Partners Currently Involved in FP Service Delivery in CRS

S/N	Partner	Role in FP delivery
1	UNFPA	Provides contraceptives to the SMOH(?) at no cost; are involved in FP monitoring and evaluation, including sharing results of data analyses with the state; piloting Sayana press in the state with no plans to scale up.
2	Marie Stopes International	Has a social franchise that supports private facilities by providing them with consumables and autoclave, and public facilities with consumables for outreach activities. They have also been building the capacity of health workers (nurses) in the state to provide FP services.
3	SFH	SFH is carrying out a women's health project (Public) and expanding social marketing project (private) in 13 LGAs in the state.
4	FHI 360	FHI360 on the SIDHAS platform trained 78 HCWs on LARCs to support its FP-HIV integration project being carried out across 38 health facilities.
5	CHEMONICS	Works on procurement, logistics and supplies management, including FP products – via a USAID bilateral project (dates?)
6	CHAI	In collaboration with FMOH, supported development of FP dashboard and trained staff on its use.
7	PPFN	PPFN is creating awareness on AYSRH.
8	MWAN, GPI, Mediatix foundation	Are involved in provision of FP services in the state.

## Appendix 2: FGD Sites

Senatorial District Sites Where FGDs were Performed	Local Governments Areas invited to participate in the FGDs
Ogoja (Northern Senatorial District)	Ogoja, Obudu , Obanliku , Bekwarra, Yala
Ikom (Central)	Ikom, Etung , Yakuur, Abi , Obubra
Calabar South (South)	Calabar Municipality, Calabar south, Biase, Akamkpa, Akpabuyo

## Appendix 3: FGD Composition

	Groups for FGDs	Number	Location
1	CHEWs and other health care providers trained by Pathfinder International	3	1 each from cluster of LGAs in North, Central, and South senatorial districts
2	Untrained CHEWs	1	From Central senatorial districts
3	LGA PHC/FP supervisors	3	1 each from cluster of LGAs in the Central, South, and North senatorial districts
4	Community leaders/ outreach implementers	2	1 each from Central and North senatorial districts
5	Trainers/supervisors	1	From the State level
6	Health professionals who used to provide LARC (Nurses / Midwives and doctors (in private practice in the state)	2	From Central and South senatorial districts
	<b>Total</b>	<b>12</b>	

## Appendix 4: List of Key Informant Interviewees

Interviewees	Number of Interviewees
<b>Federal level</b>	
Member of Technical Support Unit/M-Space	1
USAID	1
Pathfinder International – CIP Project and Advance Family Planning	2
<b>State level</b>	
Commissioner of Health (policy)	1
Director General Primary Health Care Development Agency (policy)	1
Advocacy Working Group/FP Resource Team Chairman (RT)	1
CRS Program Officer, Reproductive Health	1
State Family Planning Coordinator	1
Director, Nursing Services	1
Representative from the College of Health Technology	1
Development Partners/NGOs: UNFPA, Pathfinder International, SFH/PSI, ExpandNet, Marie Stopes	5
Representative, Department of Obstetrics and Gynecology at Tertiary Health Facility	1
<b>Total</b>	<b>17</b>



## Appendix 5: FGD Guides

### FGD Guide for Health Workers

#### INTRODUCE YOURSELF

*Thank you for meeting with me today. Your participation in this discussion is totally voluntary, questions I am going to ask don't have right or wrong answers. This conversation is completely confidential, and we can skip any question that you prefer not to answer. We will be discussing FP service delivery. Do you have any questions before we begin?*

#### Demographic and other descriptive information

1. When did you start working as a Community Health Extension worker, Health professionals (e.g. Nurses, Doctors)?
2. Which LGA and facility do each of you work in and how long have you worked in your current posting?
3. What activities do you perform in your role?
4. How well do you feel you were trained for activities that you are currently doing?
  - a. Are you also carrying out activities that you are not trained for? If Yes, can you share some of these activities with us?
5. Did you receive any training on FP while in school? (probe injectables) Do you feel this school training was sufficient for the FP work you are doing?
6. What is the perception about FP in your community?
  - a. Probe (Myths and Misconceptions)

#### Introduction to the family planning activities

7. What FP services are provided in your facility? (probe for injectables)
8. Now thinking about a pretend client named **Hope** you saw yesterday, what do you usually do when providing family planning services to your clients, please discuss what happens:

*Hope comes for immunization of her 10month old baby and you learn she wants to wait a few years before a new baby but she doesn't know much else except hearing a bit about FP. Just saying quickly, what are your steps to serve her?*

(listen for voluntary nature, contraceptive choice of full basket (all the available options etc)

  - o What did you find most challenging in helping Hope?
  - o Where are LARC/implant services provided? Probe facility only or in community/household as well?)
9. Besides serving FP clients individually at your facility, What FP-related activities do you do? (Probe outreaches/community mobilization, education sessions, household visits?)

### LARCS/implant training

10. *Regarding the training, you received from Pathfinder International and the State on LARCS/implant service provision, when was the training and what did you receive training on?*
  - o In your opinion, how well did the training you received on LARCS/ implant service provision, prepare you to provide FP services? (probe managing client counselling, demand generation, record-keeping, logistics management, anything else?)
  - o How has the training you received affected FP use in your community?
  - o What are your thoughts, about adding implants to your work (probe pluses and minuses)
  - o Since your LARCS training, about how many clients have you successfully inserted implants for? What about implant removals?
11. Do you use job aids, manual, dummies or IEC materials (e.g. poster or pamphlets) to support providing LARC services? If you run out (IEC materials), where can you get more?
  - o What support do you receive in your provision of FP services? (probe supportive supervision, from who, how often)

### For the untrained CHEWS

12. What are your views on the LARC training that you are yet to receive from Pathfinder International? How do you feel about not receiving the training and how has this affected your delivery of FP services? (Indifferent, incomplete, unhappy)
  - a. What do you do when clients come to you for LARC services?
  - b. What suggestion(s) if any, do you have to ensure that all CHEWS receive training for LARC service provision?

### Barriers to the Delivery of LARC/ Implant Services

13. Since you started providing implants, what are some of the facilitators/challenges or barriers you experienced during the delivery of LARC services to clients?
  - o logistics/supplies/commodities
  - o supervision
  - o leadership/coordination
  - o physical facilities and equipment
  - o consumables (probe community ability to pay)
  - o friction from other health personnel
  - o clients lack of confidence in CHEWS
  - o cultural and religious beliefs
14. What are the things that have helped or improved your service delivery?
15. What advice will you give to improve service delivery of LARCS (Implants)?
16. Can you share with me, some of your experiences and lessons learned while delivering implant/LARC services to members of the community? Probe on:
  - a. Successes (Have you been able to insert or remove implants successfully?)
  - b. Failure (Do you have many clients coming back to complain of side effects e.g. Infection, poor insertion.

- c. Did you have concerns or fears when first starting to insert implants? What were these?
  - d. How were these overcome?
  - e. Gaps in delivery of FP task-shifting/ sharing (Supervision, demand generation, training, logistics and commodities)
  - f. Areas needing strengthening (Supervision, demand generation, training, logistics and commodities)
17. What are your suggestions/ideas for how to **sustain and expand** LARC services in CRS?
18. What are your views regarding family planning task- shifting scale up effort being implemented in Cross River state? Do you think that your ability to provide implants is considered a priority for the health system? Why/why not?
- (If time: What is your favourite / best experience as a CHEW?)

*We have reached the end of the interview. Is there anything else you would like to say, or do you have any questions for me? Thank you for your time and participation today.*

## FGD Guide for LGA FP Supervisors and PHC Coordinators

### INTRODUCTIONS FIRST

*Thank you for meeting with me today. Your participation in this interview is totally voluntary, questions I am going to ask don't have right or wrong answers. This interview is completely confidential, and we can skip any question that you prefer not to answer. We are interested in knowing your views and opinions, regardless of whether you agree or disagree with what you hear. It is very important we hear all your opinions. We will ensure that your views are not linked to you. Do you have any questions before we begin? (Interviewer first introduces themselves and states they are Researchers from E2A.)*

This qualitative assessment aims to document the process of implementing the CRS strategic FP- scale up plan and to identify the needs for and barriers to scale up of task- shifting services in Cross River state.

### Demographic and other descriptive information

1. What is your cadre and your job description?
2. How long have you worked as an FP supervisor or PHC coordinator at the LGA?
3. How do members of your community perceive FP based on your experience? (Probe: CHEWs themselves, Demand/Community perspective, etc.)
4. What FP services are available in your LGA? (probe, at facility or community level and by whom)?
  - a. Have you been introduced to the TSTS policy? What is your opinion about the policy? (How do the health workers who used to deliver these services feel about this change? Did this free them up to do other things)

### Barriers and Facilitators to LARC/Implant service delivery

5. Since the LARC training by Pathfinder took place for CHEWs in your LGA, what has worked well?
6. What areas do you think need strengthening? (probe logistics, demand creation, funding, supervision)? OR What are the barriers to delivery of FP services in your LGA?
  - a. Probes
  - b. logistics/supplies/commodities
  - c. supervision
  - d. leadership/coordination
  - e. physical facilities and equipment
  - f. consumables (probe community ability to pay
  - g. friction with other health personnel
  - h. religious and cultural beliefs
7. What are some of your concerns for how to sustain and expand access to implants in your LGA?

Is there anything else you would like to tell us?

*We have reached the end of the interview. Is there anything else you would like to say, or do you have any questions for me? Thank you for your time and participation today.*

## FGD Guide for Community Influencers

*Thank you for meeting with me today. Your participation in this interview is totally voluntary, questions I am going to ask don't have right or wrong answers. This interview is completely confidential, and we can skip any question that you prefer not to answer. We are interested in knowing your views and opinions, regardless of whether you agree or disagree with what you hear. It is very important we hear all your opinions. We will ensure that your views are not linked to you. Do you have any questions before we begin?*

*(Interviewer first introduce themselves states they are Researchers from)*

1. Tell us about yourself and your various roles in your community?
2. What are your views about the use of Family planning? How do you think your community members perceive family planning?
3. Do you know that there is a 2014 Nigerian policy that allows CHEWs to share certain medical tasks, including providing family planning services? If yes, what are your thoughts on this policy? (Try to explain what TSTS policy is)
  - o Probes
  - o Benefits of the Task Shifting policy
  - o Disadvantages of the TSTS policy.
  - o Views on specific types of family planning methods
4. Have you received any visits concerning family planning service provision in your community? (Have people come to tell you about TSTS policy and who came)
5. What has your contribution (if any) been towards your community accessing FP services? (probe awareness creation, community mobilization, providing space for outreach, your endorsement).
6. What have others in your community contributed to expanding access to FP in your community? (probe awareness creation, community mobilization, providing space for outreach, your endorsement).
7. Do you speak publicly about the use of family planning? If yes, what do you say? If No why?
8. Within your community, can you share some possible facilitators and some barriers towards expanding access to FP in your community?

*We have reached the end of the interview. Is there anything else you would like to say, or do you have any questions for me?*

## FGD Guide for Trainers/Supervisors

*Thank you for meeting with me today. Your participation in this interview is totally voluntary, questions I am going to ask don't have right or wrong answers. This interview is completely confidential, and we can skip any question that you prefer not to answer. We are interested in knowing your views and opinions, regardless of whether you agree or disagree with what you hear. It is very important we hear all your opinions. We will ensure that your views are not linked to you. Do you have any questions before we begin? (Interviewer first introduce themselves states they are Researchers working with Evidence to action(E2A) and Pathfinder I)*

This qualitative assessment aims to document the process of implementing the CRS strategic FP- scale up plan and to identify the needs for and barriers to scale up of task- shifting services in Cross River state.

### Demographic and other FP related information

1. What is your cadre and your job description?
2. How did you become an FP trainer? What were the basic components of your training? When was the training received?
3. To what extent do you think the training was sufficient for you to carry out your job? Were there any gaps associated with trainings received and in which areas?
4. How many step-down trainings have you conducted since you became a trainer?
5. For trainers who have been training since the beginning of implant provision, has the duration or content of the training changed over time? Probe for shortened, shifted between classroom or practical, etc.)

### Supervisory Visits

6. How do you supervise CHEWs who have been trained for implant provision? What is involved? Probe: documentation, observation, etc.
7. What resources and materials do you use when training providers? During supervision? Where did you get these materials? What were you given from your training? Are any other materials needed?
8. Are you aware of the TSTS policy? What is your opinion about the policy?
9. Are you aware of the planning process for scaling up strategy development process for the TSTS policy enabling CHEWs to provide implants that began in February 2017 for the State?
10. For those who participated in the scale up planning meeting, what was your view on the value of the planning process and why?

### Barriers and Facilitators

11. Since you became a trainer what has worked well in implementing the TSTS policy? What areas do you think need strengthening? (probe logistics, demand creation, funding, supervision)? OR What are the barriers to delivery of FP services in your LGA?
12. How has the TSTSP affected other cadre of health workers ? Do you see any friction from other health professionals since the task-shifting policy was domesticated and being implemented in CRS?

13. What are some of your concerns on how to sustain and expand access to implants in the state?
14. Moving forward, what are some of your suggestions/ideas on how to sustain and expand access to implants in your LGA?
15. Please feel free if there is anything else you want to tell us?

*We have reached the end of the interview. Is there anything else you would like to say, or do you have any questions for me? Thank you for your time and participation today.*

## Appendix 6: Key Informant Interview Guides

### Individual Interview Guide for program managers, policy makers, and partners

#### INTRODUCTION

*Thank you for meeting with me today. Your participation in this interview is totally voluntary, questions I am going to ask don't have right or wrong answers. This interview is completely confidential, and we can skip any question that you prefer not to answer. We are interested in knowing your views and opinions, regardless of whether you agree or disagree with what you hear. It is very important we hear all your opinions. We will ensure that your views are not linked to you. Do you have any questions before we begin? (Interviewer first introduce themselves states they are Researchers working with Evidence to Action (E2A) Project and Pathfinder)*

This qualitative assessment aims to document the process of implementing the CRS strategic FP scale-up plan and to identify the needs for and barriers to scale up of task-shifting services in Cross River state.

Task-shifting became necessary owing to the shortage of skilled health workers in Nigeria accentuated by maldistribution of available cadres skewed in favor of the urban locations particularly in Southern states in the country. The findings from this study will inform decision makers on possible ways to improve access to and provide quality family planning services using the task-shifting strategy. It will also serve as guidance for policy makers and program managers on how to strengthen and scale up delivery of family planning services in the country based on perceptions and lessons learnt by relevant stake holders involved in the program.

#### Background information

- Official title
- Place of work and duration of work in that position

#### Views on National Task Shifting/Sharing policy

*Nigeria's health system is currently challenged by shortage of Health workers particularly in the rural areas where more than 70% of the populace resides.*

1. Have you heard about the National Task Shifting/Task Sharing? What are your views about the policy? **(Explain what TSTSP is about, and ask respondents views on the policy.)**
2. Have you heard about the policy currently being operationalized in the state? What are your views about implementation of the policy?
3. Please describe your role/your organization's current role(s) in supporting implementation of the Family planning Task-shifting process?

#### Probes

Possible functions/ roles

- Finance /financial management (How is family planning currently being funded?)
- Human resource management (training, supervision, M&E, etc)



- Dissemination and advocacy (What efforts have been made in the area of advocacy to relevant stakeholders to embed FP task shifting into norms, budgets, regulations, programme frameworks, policies, etc)
  - Monitoring and evaluation of process and results
4. What was your impression of the FP task-shifting policy initially and what is it now that it is being implemented in CRS? Has it changed? Could you tell us why your opinion has stayed the same or shifted?
  5. Considering the delivery of FP services in CRS, please describe some of the tasks/duties you think should be shared / shifted to these lower cadre of health workers? FP education and counselling, Initiation and maintenance of injectable contraceptives, Insertion of IUCD, Barrier methods(condoms), pills, Surgical methods (Vasectomy-men, Tubal Ligation for women), Promote dual protection for HIV positive women)
    - Probe: what condition(s) must be met before these health workers are assigned roles and responsibilities?
    - Can you speak a little about what you base your suggestions on?
    - What do you think should **NOT** be shifted? Why do you think that it should not be shifted?
  6. What is your impression about enabling CHEWs to provide contraceptive implants? (Probes: Quality of care, any concerns? Pros and cons?)
  7. How has TSTSP affected your work? If you supervise others, has the policy affected your work or for the people you supervise/oversee? What has changed for the CHEWS, Nurses, FP coordinators? Has it been positive, negative, or neutral? (Probe for successes and challenges)? (FP coordinator, Nurses, doctors)
 

Probes

    - Policy context and political system,
    - Health financing from within the government system
    - Availability of partner/donor support,
    - Bureaucratic structure and culture
    - Health or other relevant governmental sectors,
    - People's socio-economic and cultural factors
    - People's needs and rights

Scaling up of the Family planning commodities through task-sharing in Cross River state.

#### FP-Scaling up Strategy Development Process

8. As a participant in the strategy development process, Can you share with us your thoughts about the process of developing the CRS FP scale up strategy? (Nine step approach)
  - What did you think of that process?
  - Was it Useful or not? Demanding? Clear and easy or difficult?
  - Was it inclusive? Were the major stake holders represented?

- Did the participants have the information they needed about needs, priorities, available resources etc to participate meaningfully?
  - Was it different from other planning activities you have been involved in? IF yes, In what ways?
  - Was there anything in your opinion that you think should have been done differently in the strategy development process for FP scale up in the state? (was it too technical, overwhelming, overloaded or just adequate)
9. How has the strategy that was developed been implemented so far?
- Training of TRAINERS and CHEWS
  - Family planning commodities
  - Supportive supervision
  - Social mobilisation activities
  - Could you tell us if implementation has been evenly implemented throughout the state or not and if not, why not?
- What was the criteria for selection of CHEWs for LARCs training? (State FP. Coordinator)

#### Barriers and facilitators to task-shifting scale-up efforts in CRS

10. In your own opinion can you tell us what has worked well in the implementation of the FP scale up efforts in the state?

##### Probes:

- trainings
- logistics/commodity supplies
- supervision
- leadership/coordination (Role played in leadership)
- demand generation
- funding

11. What **bottlenecks/difficulties** have you encountered, or do you perceive exist in the implementation scale up efforts of FP-implant provision by CHEWs?

##### Probes:

- Technical skills
- Certification of CHEWS
- Commitment of CHEWs
- training
- commodity supplies
- supervision
- leadership/coordination
- demand generation
- political will
- funding/logistics
- other health personnel

- religious and traditional

Of the challenges you described, what do you think was the greatest challenge? Why?

How did you or your team deal with this challenge?

12. What opportunities are there to provide a significant boost to the implementation of task-sharing of Family planning services (mainly implants) in Cross River State? (Probes: political, structural, religious, funding etc)
13. Using CHEWS to deliver LARC in their communities, what challenges to ensuring sustainability of scaling up of this health innovation do you envisage and how can this be tackled?
  - (Probe for economic, social, religious, cultural, political challenges, availability of skilled personnel etc)
14. Why do you think scale-up has been successful in some areas more than others?
15. Do you have any suggestions on how to improve delivery and ensure that we achieve 100% scale up of the FP task-sharing in the state?
  - What further changes may be needed in policies, norms, regulations or other health-systems components to institutionalize the innovation?
    - Preservice education
    - Budgeting

*We have reached the end of the interview. Is there anything else you would like to say, or do you have any questions for me? Thank you for your time and participation today.*

## Appendix 7: Concise Version of the Systematic FP TSTS Scale-Up Strategy

Broad Category	Recommendations	Degree of Priority
Improve awareness of the credibility of the innovation	<ul style="list-style-type: none"> <li>• Print and distribute CRS domesticated task-sharing policy to all stakeholders in the state</li> <li>• Resource Team to share quarterly written reports with members and key stakeholders</li> <li>• Leverage existing partners' forums in the state to disseminate key elements of the strategy and implementation of the policy</li> </ul>	MODERATE
Conduct trainings for nurse-midwife trainers and CHEWs on provision of LARCs	<ul style="list-style-type: none"> <li>• Train (an additional) 14 master trainers in the state</li> <li>• Develop and disseminate policy/criteria for selecting trainees</li> <li>• Conduct stepdown in-service training for CHEWs with a focus on the 1 functional PHC per ward</li> <li>• Ensure inclusion of training on FP/LARC service delivery in pre-service training curriculum for CHEWs</li> </ul>	HIGH
Establish quality assurance measures	<ul style="list-style-type: none"> <li>• Create a center of excellence at the schools for in-service CHEWs who have not received prior training on LARCs to acquire the skills and get certified</li> <li>• Establish a peer-to-peer mentoring system among CHEWs following training (i.e., CHEWs trained in Phase 1 to provide mentoring to phase 2 CHEWs)</li> <li>• Conduct monthly supportive supervision of trained CHEWs</li> <li>• Ensure trainings use the nationally approved FMOH training curriculum</li> </ul>	HIGH
Logistics security	<ul style="list-style-type: none"> <li>• Integrate the FP commodities/consumables into the central commodities purchasing and distribution system</li> <li>• Use existing state tool for documenting FP logistics management</li> </ul>	HIGH
Conduct an analysis of the environment	<ul style="list-style-type: none"> <li>• Conduct a survey of the state sociocultural and economic environment to identify specific barriers to FP uptake in the state, with a view to addressing them</li> </ul>	MODERATE
Expand demand generation activities	<ul style="list-style-type: none"> <li>• Expand demand generation activities by leveraging identified existing community mobilization efforts and other demand generation activities</li> <li>• Engage the media for dissemination and advocacy around FP on TV, radio, and social media platforms</li> </ul>	HIGH
Advocate integration and institutionalization of the intervention package	<ul style="list-style-type: none"> <li>• Advocate with the state to include the intervention in its annual operational plan</li> <li>• Advocate for inclusion of FP commodities in state distribution system</li> <li>• Advocate review of policies to increase use of key development indicators, such as poor maternal health</li> </ul>	HIGH

	<p>indices (e.g. CRS' 60% births without a skilled birth attendant), as main determinants of budget allocations</p> <ul style="list-style-type: none"> <li>• Ensure alignment of FP TSTS scale-up efforts with the one PHC per ward program in line with the SMOH/PHCDA plan</li> <li>• Support and encourage donor-funded initiatives to align workplans to advancing this strategy</li> </ul>	
Engage the private sector to complement implementation of the innovation	<ul style="list-style-type: none"> <li>• Develop a communique to private sector providers and facilities requiring them to hire trained professionals</li> <li>• Review findings from the SHOPS work in Nigeria to draw lessons learned to inform policymaking</li> <li>• Encourage the state to develop a contractually binding policy on government distribution of FP commodities to the private sector to make FP services available at subsidized rates</li> </ul>	HIGH
Resource mobilization	<ul style="list-style-type: none"> <li>• Advocate for a separate and independent budget line for FP in the state budget</li> <li>• Mobilize additional funding streams from the private sector (e.g., professional associations) to help support FP basket funding</li> <li>• Conduct resource mapping to ensure that existing opportunities and resource pools are being fully utilized</li> </ul>	HIGH
Stewardship	<ul style="list-style-type: none"> <li>• SMOH to support the process of identification of sites qualified to provide practicum experience as part of pre-service education curriculum</li> <li>• Draft an SMOH policy brief/memorandum that lays out key principles, with existing evidence on job-sharing successes in Nigeria</li> <li>• Resource Team to identify and assign roles and responsibilities for implementation among the user organizations and assist SMOH to draft and distribute a communique to all</li> </ul>	HIGH
Communication	<ul style="list-style-type: none"> <li>• Circulate quarterly soft copy reports/newsletters on progress</li> </ul>	LOW
Monitoring and evaluation	<ul style="list-style-type: none"> <li>• RT to Identify indicators for use in capturing the progress of the scaling-up process</li> <li>• Monitoring should be intensified at all levels – training, implementation, supportive supervision, FP uptake, and commodity logistics</li> <li>• Existing tools/systems should be used pending review of said tools</li> <li>• Monitor and measure institutional change, monthly, through virtual meetings</li> </ul>	HIGH

<p><b>Strengthen the Resource Team (RT)</b></p>	<ul style="list-style-type: none"> <li>• Resource Team to appoint key officials (Chairpersons, Secretary, etc.) at its first formal meeting</li> <li>• Membership of the RT should be expanded to include other players with different mix of strengths and abilities (beyond technical know-how)</li> <li>• Review progress on institutionalization/scaling-up process during quarterly meetings of the RT</li> <li>• Hold smaller one-on-one meetings quarterly meetings with key members of the RT to decentralize, thereby encouraging participation</li> <li>• Ensure inclusion of an activity budget line for support of the scale-up RT in the state costed implementation plan (CIP)</li> <li>• RT to establish sub-units (e.g., Technical Working Group, M&amp;E unit, environmental scanning unit)</li> </ul>	<p>MODERATE</p>
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<sup>1</sup> WHO. *WHO recommendations Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting*. OPTIMIZEMNH. Geneva: WHO, 2012.

<sup>2</sup> WHO. *Trends in Maternal Mortality: 1990-2008*. Estimates developed by WHO, UNICEF, UNFPA and The World Bank. WHO, 2010.

<sup>3</sup> Okyere E, Mwanri L, Ward P. "Is task-shifting a solution to the health workers' shortage in Northern Ghana?" *PLoS ONE*. 2017;12(3):e0174631.

<sup>4</sup> Federal Ministry of Health (Nigeria). *Task Shifting and Task Sharing Policy for Emergency Obstetric and Newborn Care Services in Nigeria*. 2013.

<sup>5</sup> WHO. *Task Shifting - Global recommendations and guidelines*. Geneva: WHO, 2008.

<sup>6</sup> Stanbeck J, Mbonye AK, Bekiita M. Contraceptive injections by community health workers in Uganda: a nonrandomized community trial. *Bulletin of the World Health Organization*, 85 (10), October 2007.

<sup>7</sup> WHO, 2010.

<sup>8</sup> National Population Commission (NPC) Nigeria and ICF International. *Nigeria Demographic and Health Survey 2013*. Abuja, Nigeria/Rockville, Maryland, US: NPC and ICF International, 2014.

<sup>9</sup> Loto O.M, et al. 2004. Poor Obstetric Performance of Teenagers: is it Age- or Quality of Care-related? *J Obstet Gynaecol*, 24(4):395-8.

<sup>10</sup> 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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## EVIDENCE TO ACTION PROJECT

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