USAID | DELIVER PROJECT

Malawi: Distribution of DMPA at the Community Level

Lessons Learned

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Abstract
In 2008, Malawi piloted the distribution of DMPA to the community by Health Surveillance Assistants. This report presents lessons learned during the initial implementation—from gaining stakeholder buy-in to curriculum development—and the initial three months after the training and implementation roll-out.

The report presents lessons learned that will be valuable for other countries considering similar community-based distribution, with particular attention paid to the supply chain implications of distributing family planning commodities to the last mile.

Cover photo: A nurse reviews distribution records with a Health Surveillance Assistant during a field supervision visit in Salima, Malawi, in June 2009.

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ACRONYMS

AMC	average monthly consumption
BSM	*Banja La Mtsogolo*
CBD	community-based distribution
CBDA	community-based distribution agents
CMS	Central Medical Stores
CPR	contraceptive prevalence rate
DHO	District Health Office
DMPA	depo-medroxy progesterone acetate
HSA	Health Surveillance Assistants
LMIS	logistics management information system
MDG	Millennium Development Goal
MOH	Ministry of Health
MSH	Management Sciences for Health
NGO	nongovernmental organization
PSI	Population Services International
RHU	Reproductive Health Unit
RMS	Regional Medical Stores
SOP	standard operating procedure
SWAp	sector wide approach
USAID	U.S. Agency for International Development

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The authors would like to thank all those who provided information and feedback on their experience with community-based distribution (CBD) of depo-medroxy progesterone acetate (DMPA)—also known by its brand name, Depo-Provera. We would particularly like to thank staff from Management Sciences for Health, USAID | Health Policy Initiative, and the USAID | DELIVER PROJECT colleagues in Malawi. Also, thank you to Fannie Kachale for her insight on how the CBD of DMPA in Malawi began, as well as her colleagues in the Reproductive Health Unit and other sections of the Ministry of Health for tirelessly working to implement this project. Lilly Banda-Maliro was also instrumental in guiding the direction of the initial lessons learned.

Finally, the authors would like to express gratitude to the Health Surveillance Assistants (HSA) for all of their hard work in trying to bring a variety of family planning options all the way to the last mile: to women without easy access to family planning. Without their dedication, CBD programs would not exist.

INTRODUCTION

REASON FOR PILOT

Family planning and reproductive health remains a challenge in many parts of Malawi. The national contraceptive prevalence rate (CPR) for all contraceptive methods is 42 percent. The total fertility rate (TFR) remains high at 5.6;[1] the Ministry of Health (MOH) is committed to decreasing this number.[2] Some of the challenges to meeting this goal include unmet need because of poor availability of contraceptives. Contraceptive security is defined as the ability of all men and women to chose, obtain, and use a wide range of high-quality, affordable contraceptives. Many countries have implemented a variety of interventions to increase contraceptive security.

In Malawi, one such effort is the community-based distribution of depo-medroxy progesterone acetate (DMPA)—also known by its brand name, Depo-Provera. The program trains Health Surveillance Assistants (HSA) to administer DMPA to women in their community. The contraceptive injectable, given once every three months, is usually administered to women in the health facility. However, women who live far from the health facilities may not have the time or transportation to travel to the health facility for an injection every 12 weeks.

Often wait times at health facilities are long—another factor that prevents women from seeking out DMPA; also, health facilities are often over-crowded. Permitting community members to administer DMPA would allow women to circumvent the long lines and alleviate some of the work load at these health facilities.

The U.S. Agency for International Development (USAID) provided support to the Reproductive Health Unit (RHU) of the Malawi MOH to pilot the community distribution of DMPA. Management Sciences for Health (MSH) is the lead project among collaborating agencies and partners, including the USAID | DELIVER PROJECT.

BACKGROUND

In 2002, the MOH, through the Essential Health Package, proposed to provide more comprehensive family planning services at the community level. For several years, Community-Based Distribution Agents (CBDAs) have provided family planning services to their communities (oral contraceptives and condoms). However, as demand and availability for these products increased, so did the demand for the injectable form of the contraceptive DMPA.

The Malawi Demographic and Health Survey of 2004 states that 64 percent of currently married women who use a modern contraceptive method use injectable contraceptives. Yet access to this form of family planning is still difficult, particularly for people living in hard-to-reach areas. Eighty-three percent of Malawi's population lives in rural areas.

[1] UNICEF. 2008. *State of the World's Children 2009*. New York: United Nations Children's Fund.

[2] National Statistical Office (NSO) Malawi, and ORC Macro. 2005. *Malawi Demographic and Health Survey 2004*. Calverton, Md.: NSO and ORC Macro.

The RHU saw the increased demand for DMPA; they saw the unmet need as an opportunity to increase contraceptive security and to improve Malawi's progress toward Millennium Development Goal 5, Improved Maternal Health. Community-based distribution (CBD) of DMPA was seen as a great opportunity to close that gap. In working with the RHU, the USAID Mission in Malawi requested the USAID | Health Policy Initiative, Task Order 1, assess the feasibility and acceptability of providing injectable contraceptives through CBD. Using stakeholder interviews and focus group discussions, they evaluated the acceptability of distributing DMPA at the community level.

Before the study, CBDAs were already being considered for the work, as they were providing other family planning methods using CBD. However, it became clear that HSAs would be a more acceptable option for the local context; HSAs were perceived to be better suited for the work expected of them. The new task of providing DMPA would be an easy transition as HSAs were already trained to provide vaccinations.

As a matter of fact, the feasibility study discovered that some HSAs had previously been providing DMPA because of the need they saw in their communities. Some, as in the district of Zomba, were officially distributing it because the health facilities, being Catholic, would not provide family planning services. However, there were also isolated instances where, without the approval of the MOH, HSAs were providing DMPA to accommodate requests from their community. However, they were stopped when the MOH discovered they were distributing without authorization.

HSAs are also a salaried cadre of the MOH, whereas the CBDAs are not. This proved to be another convincing factor to work with HSAs rather than CBDAs.

It was important for the HSAs to receive not only clinical and technical training on the actual administration of DMPA, but also training on the management of their supplies. Having an adequate supply of products to meet clients' needs is crucial to the success of health programs, particularly a CBD program. The USAID | DELIVER PROJECT's role was to train HSAs on logistics management, including recording and reporting of consumption data, keeping records of stock on hand, calculating resupply quantities, and determining when to resupply. Because the HSAs were handling needles and syringes, the training also covered the safe disposal of sharps and other health care waste.

IMPLEMENTATION

MADAGASCAR STUDY TOUR

To help stakeholders better understand the implications and benefits of community-based distribution (CBD), with the support of USAID, a delegation comprising the Malawi MOH, the USAID | DELIVER PROJECT, and other organizations, attended a study tour to Madagascar in June 2008. Participants saw the CBD program in action. The trip highlighted the potential for using CBD to ease the work load at health facilities. Seeing the program firsthand helped obtain political buy-in for the initiative in Malawi.

The objectives for the study tour were to—

- gain firsthand experience of Madagascar's efforts using CBDAs to provide DMPA—also known by its brand name, Depo-Provera, at the community level
- identify lessons learned from the Madagascar initiative and approaches used to overcome challenges and obstacles
- identify specific issues and concerns that would need to be addressed in replicating a similar initiative in Malawi
- provide lessons learned and develop suggestions and recommendations that will be presented at a larger stakeholders' meeting on the CBD of DMPA in Malawi.

The USAID | DELIVER PROJECT looked specifically at the supply chain management of DMPA. Some of the observations from a supply chain perspective are summarized below.

Strengths

The Madagascar supply chain system is strong. There is strong collaboration with partners, reporting rates are high because they are linked to resupply, and supervision is strong. Bi-monthly distribution of supplies to districts, availability of enough storage space, and the high maximum and minimum stock levels at the district level enable the system to reduce resource requirements at the central level. This can result in less money and administrative time invested in distribution and more invested in supervision. Every community-based distributor of DMPA has a sharps box for the disposal of sharps. When it is full, the CBDA brings the box to the health center for disposal.

Weaknesses

However, proper storage techniques were not followed at the district and CBDA levels. The box provided to the CBDA did not have enough space for all the products, which prevented easy first-to-expire, first-out (FEFO) practices. Also, non-health products were kept in the same box. The box could not be locked, which led to several instances of drug theft at sites in the district visited.

Additionally, CBDAs did not report stock on hand or losses and adjustments; therefore, logistics data was not used to calculate resupply quantities and CBDAs were not resupplied based on

consumption and stock on hand. As the maximum and minimum stock levels are high throughout the system, there is a potential for huge losses due to expiry of products.

STAKEHOLDERS' CONSENSUS BUILDING MEETING

After the study tour, a stakeholders' meeting was held in Lilongwe on July 15, 2008. The theme was "The Way Forward: Malawi's Road to community-based distribution of DMPA."

The objectives of the meeting were to—

- share findings of the USAID | Health Policy Initiative research on evaluating community views about CBD of DMPA
- share lessons learned from the Madagascar study tour on CBD of DMPA
- build consensus on the paramedical provision of DMPA.

The meeting was organized by Malawi's RHU, in collaboration with the USAID | Health Policy Initiative. Additional participants included MSH, USAID | DELIVER PROJECT, Adventist Health Services, and Population Services International (PSI). By making a presentation on the need to expand access to DMPA and a review of what was seen during the Madagascar study tour on CBD of DMPA, facilitators built support for using HSAs to distribute DMPA. The second half of the meeting included group work—participants focused on setting priorities and citing next steps in three areas: guidelines and standards, training, and supervision. A task force was assigned to develop training materials; Management Sciences for Health was selected as the lead for the pilot project.

The resulting project plan consisted of the following steps: curriculum development, training-of-trainers, a curriculum pre-test, and program rollout. The pilot would be located in the eight districts where MSH works, with the later addition of one district overseen by Adventist Health Services.

CURRICULUM DEVELOPMENT

A variety of partners were extensively involved—they assisted with the development or review of the curriculum. The training plan consisted of the training of in-country trainers, who, in turn, would train the HSAs. Having a curriculum that included all aspects of the training that HSAs were to undertake in one document facilitated not only the roll-out of the initial training for the pilot but also the basis for a national roll-out; based on that information, the MOH decided to proceed in that direction. The in-service training curriculum was divided into three topic areas for development. (1) Management Sciences for Health (MSH) was charged with the clinical aspects, (2) the USAID | Health Policy Initiative was responsible for the policy portions, and (3) the USAID|DELIVER PROJECT was responsible for the logistics portion of the curriculum. All three sections were combined to form one complete manual. Drafts of each section were shared by email with other members of the task force for comments. In addition to the aforementioned partners, *Banja La Mtsogolo* (BSM), a partner of Marie Stopes International, and the Malawi College of Medicine assisted in its review. Their comments were then integrated into the final curriculum product.

Of the six-day training course, only four hours covered supply chain management. The USAID | DELIVER PROJECT advisors were concerned that because of the large quantity of non-logistics material covered in the course, and the fact that the logistics content covered only the basics, the HSAs might not feel completely prepared to manage their supplies after the training. To provide additional support to the HSAs in supply chain management, the project developed a companion document that explained the standard operating procedures (SOPs), in detail, including examples. In

addition to the explanations, this document also links the program to the national supply chain system. This companion SOPs document was given to trainees as a reference guide, but it was not used during the training.

TRAINING-OF-TRAINERS

Trainers were selected from the group of trainers within the MOH who have been training HSAs for their initial ten-week course for a long time. Thus, they were already familiar with many of the techniques, their audience, and the initiative. The logistics portion of the training was conducted by the USAID | DELIVER PROJECT Malawi field staff.

CURRICULUM PRE-TEST

Four districts were chosen to pilot the training material in October 2008: Kasungu, Salima, Balaka, and Zomba. From the districts where MSH works, one district in each of the three regions was chosen at random. Zomba, the district where Adventist Health Services works, was added. Trainings at each district consisted of 20 HSAs and five supervisors, for a total of 80 HSAs and 20 supervisors.

The following criterion was used to select the HSAs:

- experienced as a HSA
- located in hard-to-reach communities (>18 km from a health facility)
- has a minimum of Junior Certificate of Education (secondary level)
- well respected in the community.

Supervisors are, by default, the nurse at the health facility that each of the HSAs report to. In most cases, HSAs report to the health facility closest to them.

After the training material was tested, supervisors met in Lilongwe in November 2008 to discuss and revise the training material, based on the feedback received during the pilot.

Changes to the material included—

Lengthened review sessions on family planning and reproductive health: It was assumed that HSAs who received a ten-week training to prepare for their job were familiar with family planning options and required only a review. However, during the pre-test, it was clear that a more in-depth lesson on counseling women in family planning options would be necessary.

Lengthened clinical sessions on injection technique: Similarly, HSAs struggled to adjust techniques for vaccination to that of providing DMPA, which requires different techniques. The session was lengthened to ensure good clinical practice.

English language manuals: With secondary education, HSAs were expected to have a level of English that would not require providing manuals developed in the local vernacular. However, some seemed to struggle with the technical language. To assist them, CBDA procedures manuals in the local language were distributed.

The pre-test of the curriculum also highlighted a few topics where trainers had outdated information. Thus, this time was also used to ensure that there was a standard agreement on technical details in providing DMPA.

TRAINING ROLL-OUT

After the curriculum was agreed upon, the final five districts were trained. Participants in the training were similar to the pilot for the curriculum: 20 HSAs and five nurse or medical assistant supervisors. MSH, Adventist Health Services, and the USAID | DELIVER PROJECT collaborated to conduct the training.

As in the previous training sessions, of the six days, most of the material covered focused on clinical aspects and only four hours were dedicated to logistics training.

All eight pilot districts under MSH had completed their training by March 2009, for a total of 320 HSAs and 80 supervisors receiving the training. A few remaining trainings lasted until June 2009, because Zomba covered a wider percentage of HSAs in their trainings. Draft SOPs, developed by the USAID | DELIVER PROJECT, were distributed to participants in Karonga, Chikwawa, Nihotakota, Mangoci, and Phalombe districts. Kasungu, Salima, and Balaka will receive the finalized version after it is complete.

PROGRAM ROLL-OUT

After returning from their training, HSAs were permitted to begin distributing DMPA. During most of the outreach trips, they provide DMPA to 25–40 women at each outreach clinic. Others attend to clients in their home. The initial perception by the communities of the service being provided by HSAs was a positive one. In some districts, it was an extremely easy transition because HSAs had previously been distributing DMPA, even though it was not being sanctioned by the MOH.

However, the program was such a success that many HSAs stocked out quickly. Each had been provided with 50 vials of DMPA for their initial stock. But, in the initial phase of such a program, it is difficult to estimate how much product will be used and there is a high risk of stocking out. Minimal access to transportation makes emergency orders challenging. Most HSAs used their own transportation to report to health centers for a resupply. Some walked, others biked, and many paid for taxis out of their own pocket. Unfortunately, upon arrival, many HSAs discovered that some health facilities did not have sufficient DMPA to allow them to resupply. This was due to greater supply problems that were encountered at the district and at the national levels; this is discussed in greater detail in the Challenges section of this document. Many HSAs returned from their resupply trip empty-handed; some went for longer than 30 days without any stock.

SUPERVISION STRATEGY

The training curriculum dictates no specific supervision strategy. Many different stakeholders had different interpretations of what supervision would entail. In theory, to keep commitment minimal for health facility nurses, HSAs are to report once a month to the health facility to meet as a group, share best practices, and receive resupplies. However, this situation varied, depending on the circumstances.

INITIAL MONITORING

In May 2009, staff members from the USAID | DELIVER PROJECT visited six districts to check on the initial progress of the program and to provide feedback to both HSAs and supervisors. The effort to catch early warning signs of potential problems revealed a few challenges, which are currently being addressed.

Selection Process: There were some discordant HSAs and supervisors when an HSA was to report to a supervisor located outside their health facility's coverage area. This required HSAs to travel long distances to turn in reports and resupply their stock. The distance and time required for this made it prohibitively expensive. These HSAs were stocked out with no way to resupply. Meanwhile, the health facility closest to them had an available stock of DMPA that the HSA could not access.

District-level DMPA rationing: The most essential piece of this pilot was the availability of DMPA, with HSAs to bring its availability closer to the client. However, the current situation does not guarantee that. Procurement of all health products has been decentralized to the district level.

With limited funds available, the District Health Office (DHO) is forced to make difficult decisions about what commodities to purchase. As DMPA is a preventive health measure, it currently does not rank high among the priority commodities. Districts are rationing the DMPA they are providing to the health centers; who, in turn, ration the DMPA they provide to their HSAs, if they provide any at all. So, while DMPA is available in the country, as well as in demand, districts purchased other products deemed more urgent.

Other problems encountered and to be addressed:

- poor record keeping in some health facilities
- no logistics management information system (LMIS) forms available to HSAs (districts were provided with soft copies of the form to print and distribute, but this has not happened)
- administrative issues and poor communication postponed the beginning of work for some HSAs.

STAKEHOLDERS' REVIEW

Several stakeholders' meetings were held in early July 2009, where three of the nine pilot districts discussed the initial reactions of the pilot and the challenges they have encountered. One particular topic was the implication of limited funding for DMPA procurement at the DHO.

CHALLENGES

IN THE FIELD

Training review: It was evident while interviewing HSAs that although they have a solid understanding of the broad ideas behind providing DMPA, including the very important clinical aspects, some of the details of storage practices and filling out reporting forms require a review. Even HSAs who have received attentive supervision from their supervisors, who also attended the training, were storing vials incorrectly; this, unfortunately, compromises the integrity of the DMPA.

Sharing lessons learned and ideas: Also, in addition to reviewing the use of LMIS forms, one interviewed HSA commented that he would like to share with other HSAs his experiences in discussing personal and potentially embarrassing topics with clients. A similar sentiment of wanting to share experiences was noticed across the board.

Transportation struggles: As is not uncommon for CBD programs, a constant topic of discussion during supervision and initial monitoring visits was the struggle for transportation. When first receiving training to provide vaccinations, all HSAs were supposed to be provided with bicycles. Thus, all participating in the CBD of DMPA pilot should have a bicycle because they were all, originally, community vaccinators. However, some were never given a bicycle, so a few have resorted to using their personal bicycles.

Where the bicycles were provided, HSAs feel that without the providing parts or funds for maintenance of the bicycles, the bicycle is not a long-term option. Some HSAs received their bicycles up to 14 years ago. Additional transportation is both limited and expensive for HSAs to use to collect their resupply and report for supervision meetings.

Supervision in the field: Because it is so difficult for HSAs to report to their supervisor, the supervision process is inconsistent. HSAs each report whenever transportation is available—often on different days and often unannounced. This makes resupply and supervision inefficient. Supervisors are forced to stop seeing patients while they attend to the HSAs' visits, usually several times throughout the month. To bring HSAs their supplies, some supervisors have, instead, started doing site visits to HSAs' homes every month.

Resources for implementation not standard: In a few instances, supplies for the pilot were not standardized. For example, HSAs were given storage boxes for their supplies. However, they were commissioned to be built by carpenters in each district, and some were made too small, which forced the HSAs to store their boxes of DMPA sideways instead of upright; this could compromise the product's integrity. Also, many could not be locked or were missing the lock that the storage box was supposed to have.

In addition, not all DHOs were given LMIS forms for reporting. Electronic copies of the forms were given to the DHO to distribute printed copies to HSAs and supervisors, but this did not happen in all settings. Because this was not being done, MSH field agents were overwhelmed by requests for copies of the forms.

Product availability: Some districts are rationing DMPA supply because of a misunderstanding about the cost of the product to the DHO and a reluctance to invest large amounts of their budget into preventive, rather than curative, care. Because of the DHOs' rationing, health facilities only have a short supply. Many are opting to keep DMPA at facilities, but do not provide enough for community distribution to the HSAs. Some do not have DMPA within the facilities. Should this continue, and requested resupply quantities are not provided to HSAs, they may lose motivation or their quality of work could decline. Women, after being turned away because of stockouts, may stop considering HSAs to be a viable provider of DMPA, despite their being the most convenient and accessible option.

AT THE CENTRAL LEVEL

Political buy-in: Initially, some officials were resistant to the pilot program. Members of the regulatory authorities and upper management were particularly uncertain that HSAs would be capable of handling the clinical and logistical aspects required of them. Only through persistence did members of the RHU and others involved, such as the USAID | Health Policy Initiative, convince their colleagues that community distribution of DMPA was a program worth investing in.

Unclear Supervision Strategy: All HSAs, trained to distribute DMPA or not, are supervised by the District Environmental Health Office. However, when selecting supervisors to participate in the training for DMPA distribution, it was felt that nurses would be better able to assist due to the clinical component of providing DMPA. Thus, some HSAs must report to two supervisors: the District Environmental Health Office, which has transportation and visits the HSAs in their home or where they work; and a nurse at the nearest health facility, who may or may not have transportation. HSAs are expected to come to the health facility for the DMPA supervision and to resupply. However, this varies between districts and supervisors. The training curriculum does not state clearly the expectations for supervision, which has led to inconsistency throughout the pilot program.

It also appears that although supervisors are monitoring very closely the reporting practices of HSAs, nurses provide limited feedback on storage practices and health care waste management—two very important aspects of the program and worthy of constructive feedback.

Commodity availability: The availability of DMPA to the HSAs is the most essential part of the program. However, this has proven to be a challenge in some of the pilot locations.

The procurement of DMPA and other health commodities for facilities at the district level and further down the health system has been decentralized from the national level to the DHO. The DHO is given a budget that it uses to cover administrative costs, drug purchasing from the Regional Medical Stores (RMS), and other expenses to the district health system. However, many districts feel that the funds are not sufficient, and they are forced to make difficult decisions on where to spend their funds. DMPA is often a victim during budget cuts because it is used for preventive health and is considered non-essential.

To compound this problem, DMPA will soon be stocked in the Central Medical Stores (CMS) from two different procurement mechanisms. The first, provided for free by USAID, only costs the DHO a 5 percent (of the value of the DMPA) handling fee. The second is procured by the Malawi government using World Bank sector wide approach (SWAp) funds. The DHO will purchase this at the cost of the product plus a 12.5 percent handling fee, which is significantly more expensive than the donated product. The DHOs already find the 5 percent handling fee to be prohibitively

expensive; however, the CMS, to recover costs, prefer to send out the more expensive DMPA. This issue of non-full supply has not yet been resolved. Additionally, a misunderstanding led some DHOs to believe that the more expensive SWAp-funded DMPA was all that was available for purchase from the RMS despite the fact that the SWAp-funded procurement had not yet arrived in-country.

Unfortunately, the feasibility study did not learn this information when researching product availability, nor did they talk extensively with representatives from the DHOs about their willingness to purchase preventive health products when resources are limited.

OPPORTUNITIES

LARGE AMOUNTS OF INTEREST FROM ALL LEVELS

After the initial resistance from some clinicians and pharmacists, as well as regulatory bodies, there has been a high level of interest and motivation in the CBD of DMPA. The RHU tirelessly advocated for DMPA, and multiple nongovernmental organizations (NGOs) and other stakeholders were involved in curriculum development. Healthcare providers, at both the community and facility level, see this program as a way to fill a gap and to increased access to family planning. DMPA is the preferred method for family planning for the majority of Malawian women. Initial service statistics show that utilization rates are high. Despite some initial challenges, HSAs are still motivated and doing all they can to continue to provide this service to the women in their communities. It appears that everyone wants this program to work and motivation levels are, as of now, quite high.

WRITTEN POLICY SUPPORTING COMMUNITY-BASED DISTRIBUTION

At the policy level, the Ministry of Health has just released a written policy directive stating that anyone trained in providing DMPA may provide it. This means that they have fully embraced the ability of HSAs to provide DMPA, and it also leaves the door open for CBDAs to provide it as well, without requiring another change in policy. This is a huge accomplishment for the advocacy of increasing access of the preferred method of family planning to women even in hard to reach areas of Malawi.

LESSONS LEARNED

POLITICAL BUY-IN IS ESSENTIAL TO THE SUCCESS OF A CBD PROGRAM

It was the RHU at the Malawi MOH who saw the need to expand access to DMPA to women in rural settings. They played a crucial advocacy role in encouraging others within the ministry to consider the program.

Initially, senior officials were resistant to the program. However, members of the RHU dealt with resistance through advocacy activities; repeatedly giving presentations in various quarterly meetings on the program's potential. They used talking points, pointing out that this could be a great opportunity to decrease maternal mortality and reach the Millennium Development Goals (MDG). They also highlighted similar programs' success in Uganda and Madagascar. This initial political buy-in from within the MOH went a long way toward ensuring the success of the program. The RHU have been active participants in planning and implementation.

Another factor that contributed to the MOH buy-in was a feasibility study conducted by USAID | Health Policy Initiative, on behalf of USAID. The study reiterated that receiving DMPA from HSAs would be considered socially acceptable. Also, though in Uganda and Madagascar, CBDAs were chosen to distribute DMPA at the community level, it was quickly observed that political figures and possibly even members of the community would be more comfortable with HSAs. Also, the program structure was altered to appease reservations of those unsure of the ability of CBDAs to distribute DMPA. This accommodation also drew additional political buy-in. This small change addressed the concerns that could have prevented members at the MOH from supporting the pilot.

COMMODITY AVAILABILITY MUST BE A GUARANTEE

The objective of this pilot is to increase access to an additional method of family planning at the community level, particularly to women who may have limited access to health facilities. However—no product, no program—and we have discovered that additional issues outside the MOH buy-in are required to ensure a workable pilot. The DMPA is available in Malawi and is even available at RMS. But, because many districts do not consider the benefits of access to DMPA as an additional family planning method worth the investment to keep it in full supply, product availability is limited.

To be successful, CBD programs need to be adequately supplied. A program so dependent on the availability of a product at peripheral sites, such as this, should probably not be attempted without ensuring that the product is in full supply. Additionally, major changes to factors that may affect availability, such as a change in price, should be avoided or planned for accordingly.

SUPPORTIVE SUPERVISION, THOUGH A MAJOR INVESTMENT, IS A KEY PART OF ENSURING SUCCESSFUL IMPLEMENTATION

The USAID | Health Policy Initiative feasibility study noted that feedback and supervision is a factor in keeping CBDAs motivated[3]. Presumably, this would be no different for HSAs. Particularly during the first three to six months after training, HSAs and supervisors need extensive supervision to ensure a good understanding of what they learned during the training and to solidify those lessons in practice.

The time and resources that it takes to visit each HSA is great and nurses have an extensive workload. Although not formalized, if the supervision strategy that nurses visit each HSA is maintained, program managers should make every attempt to keep the supervision process efficient. This could include integrating other planned supervisions with CBD supervision or requesting that HSAs go to the supervising nurse, rather than the nurse visiting each of the HSAs at their site.

A supervision strategy should be determined ahead of rollout and followed closely. Supportive supervision should cover a standard set of criteria, including technical, logistical, and clinical areas. Support for supervisors in how to conduct a supervision visit using a protocol or checklist could be helpful. Overlapping supervision from two programs (Environmental Health Officers and health facility nurses) could be confusing for both HSAs and supervisors.

STEP-WISE APPROACH

The decision by the MOH to use a step-wise approach to roll out this program was a wise one. This process enables implementers to work out any problems before expanding to larger coverage areas; thereby avoiding potentially costly problems. Thus, struggles with resupply and stockouts that the pilot has encountered can be resolved prior to scaling up this initiative.

However, the curriculum pre-test was wide-reaching. Four districts were included in the curriculum pre-test, almost half of the nine districts participated in the whole pilot. Thus, half of the districts did not benefit from the revised curriculum and logistics SOPs developed by the USAID | DELIVER PROJECT. Had the curriculum revision been conducted after training just one or two districts, more participants would have benefited from their improvements.

TRAINING

HSAs and supervisors have already expressed the need for refresher courses. In some of the districts, they also struggled with filling out the new LMIS form. The USAID | DELIVER PROJECT felt that four hours was not enough time to devote to training in logistics, which could be the reason for the widespread requests for a refresher course.

Additionally, the supervision process is not clearly outlined in the curriculum. The module defines supervision, but does not state clearly what should occur during the supervision process, how often it should occur, and where that should happen. The module did not provide tools or techniques in

[3] Richardson, F.M. Chirwa, M. Fahnestock, M. Bishop, P. Emmart, and B. McHenry. 2009. *Community-based Distribution of Injectable Contraceptives in Malawi.* Washington, DC: Futures Group International, Health Policy Initiative, Task Order 1.

supportive supervision. And, although the roles of the HSAs and their supervisors are quite different, their training was the same. This led to inconsistent supervision strategies. Future curriculums may want to consider being more explicit.

LOGISTICS SYSTEM DESIGN

To accommodate the limited training time in the curriculum, the logistics system design could have been adjusted to shift the burden of calculating resupply quantities to supervisors. Although most HSAs have had enough education and are probably capable of performing the calculations, there may not be a real need to burden them with training on the entire logistics system, or even on the process of calculating average monthly consumption (AMC), if their supervisors can do it.

Another option would be to use a two bin system, which eliminates the need for calculation for the HSAs and their supervisors. The HSA keeps two boxes of DMPA. When one runs out, another bin is ordered, ensuring that the HSA always has two bins of DMPA. This resupply method assumes that transport is/should be available when a bin is empty, and that the HSA does not need to wait for a monthly resupply and supervision meeting to order a new bin. Two bin systems may also be difficult to implement when consumption is difficult to forecast, like at the beginning of a new program such as this. It may require a larger buffer stock to accommodate spikes in demand. However, simplifying data collection requirements at the lowest level will ease the burden of HSAs, make their training shorter and easier, and will decrease the likelihood of calculation errors.

Finally, when initially designing the logistics system, little thought was given to how long the reporting period should be. Retrospectively, one program manager admitted that perhaps longer reporting periods could have been beneficial. This is explained in more detail below. The length of the reporting period can have a significant impact on transportation and storage space. A longer reporting period reduces transportation needs, which has been such a challenge, but increases the need for storage.

REACHING THE LAST MILE

In the words of one program manager, "We chose these sites for the pilot because they are "hard to reach". But, they are hard to reach for a reason, and it is just as difficult for an HSA to reach the health facility, or for a supervising nurse to visit an HSA as it is for a client to seek out DMPA at the health facility."

Every decision when designing and implementing a CBD program should keep this in mind. When designing the supervision strategy and reporting and resupply processes, the impact of distance and frequency should be taken into consideration. Perhaps quarterly resupply would be better than monthly. Also, buffer stock could be larger to accommodate the distance and the potential for a long lead time or stockouts in higher levels of the system. One of the most frequent comments we received from HSAs during interviews were complaints about the difficulty of traveling to and from the health facility. One way to alleviate such difficulties is to minimize the need for or frequency of the travel.

CONCLUSION

Extending health services to the community level is gaining acceptance world-wide; this may be a great opportunity to expand much-needed health services to hard-to-reach parts of a given country. There are challenges in providing such services, both political and logistical. However, the potential health benefits to be gained are likely worth the effort.

A political champion from within the MOH is a factor that will contribute greatly to overcoming political obstacles. A well thought-out plan in implementation, considering factors such as transportation, resupply quantities, data flow, and supervision strategies, will facilitate implementation.

The potential benefits in providing DMPA at the community level—the preferred method of family planning throughout Africa—is beyond measure. For countries where recent gains in reproductive health outcomes have begun to slow, CBD of the preferred family planning method could close the gap needed to reach their health goals. This pilot has shown that minimally trained health providers are capable of conducting both the clinical and logistical tasks required of them if they are well trained and supervised. Thus, when political will is there and the product is available, CBD of DMPA is a viable option in most developing country contexts.

For more information, please visit deliver.jsi.com.

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